YORKSHIRE & HUMBER
ACADEMIC HEALTH SCIENCE NETWORK

West Yorkshire and Harrogate
Health and Care Partnership

Housing for Health

West Yorkshire and Harrogate

October 2020

Foreword

Dr James Thomas
Clinical Chair for Bradford and District Clinical Commissioning Group and Co-chair of West Yorkshire and Harrogate Health and Care Partnership Improving Population Health Programme

Robin Tuddenham
CEO for Calderdale Council; Chief Officer for Calderdale Clinical Commissioning Group and Co-chair of West Yorkshire and Harrogate Health and Care Partnership Improving Population Health Programme

Welcome to our report Housing for Health

Where we live is a major determinant of our health and wellbeing – determined both by the physical nature of our homes and also the emotional and psychological impact of how secure and happy we feel with our living situation. A house may be a shelter to protect against the elements, but our sense of home is the foundation for social and psychological shelter and resilience throughout life.

For children growing up in poor quality housing we know that it will impact on their life chances as well as their lifetime health. Children living in poor or overcrowded conditions are more likely to have respiratory problems, have an increased risk of infection, mental health problems and it can also negatively impact on educational attainment.

For adults, living in insecure accommodation can have a cumulative impact for every year spent without a decent home: reducing the chances of sustaining employment, delaying or impacting on health care, increasing strain on mental health and the likelihood of relationship breakdown.

A safe, settled home is the cornerstone on which people build their independence, a better quality of life and access the services they need. Good housing is affordable, warm, safe and stable, meets the diverse needs of the people living there, and helps them connect to community, work and services.

Housing Associations are a valuable asset to our partnership for the work they do to ensure a good supply of homes and the support that goes into tenancy sustainment.

Increasingly, good housing is also about sustainable homes that are fit for purpose in the context of a climate emergency. As well as sustainable "lifetime" homes where the quality and design of housing supports lifetime physical independence as well as continued connection to the wider community. As our population ages we need housing that supports our ambitions that people can age well in West Yorkshire and Harrogate and that can only be achieved if we are planning for that now.

The importance of a good home environment has never been more acutely in focus than during the Covid-19 pandemic and the sheer scale of housing related inequality has only widened and deepened other inequalities.

For some people spending more time at home has meant being in a place where they can continue to work, they feel safe, they are with people they have chosen to be with, where their family is safe and they can enjoy time individually as well as together inside the home or in the garden.

For others, their time has been spent in a home with no access to outdoor space, or in an environment that is hazardous or overcrowded without the ability to work from home. For some people the feeling of being unsafe is constant because of the fear of crime, anti-social behaviour or living in an abusive household where domestic violence has become more frequent.

For housing there can be no return to business as usual. There are too many valuable lessons to be taken from this experience. Action is needed to ensure everyone across West Yorkshire and Harrogate has access to a warm, affordable, safe and secure home.

The agility of our local response from all partners to prevent homeless people and rough sleepers bearing the brunt of the epidemic during the early stages of lockdown has been phenomenal. We now must capitalise on those shared local responses to ensure that everyone gets the chance they deserve and the support that they need to access the right housing option for them.

Good housing is a fundamental driver of good health. As with the other determinants of good health though, it does not do so in isolation. The quality of housing, the environment it sits in and the infrastructure that serves it are all interconnecting factors on how it combines to promote basic good health. All of which is sat in a complex context of policy, funding and the state of the local, regional and national economy to ensure that quality housing is available and affordable.

Perhaps because the landscape is so complex in the UK, we have not yet maximised the best possible policy and funding levers to ensure that good housing and good health are planned together and work together for the maximum benefit. Increasingly in West Yorkshire and Harrogate however, we are finding ways to ensure that we do join up our conversations on the planning of factors for good health with the planning and delivery of our health services.

Our report shares with you a collection of good practice examples of housing, health and social care partnerships. This is the start of our work to unlock the potential of housing for health across West Yorkshire and Harrogate.

I would like to thank everyone who has contributed to this report, who share our ambition for 'better health and wellbeing for everyone'.

Foreword

Richard Stubbs, CEO, Yorkshire and Humber Academic Health Science Network

Supporting health and housing across West Yorkshire and Harrogate

The Yorkshire and Humber AHSN has welcomed the opportunity to partner with colleagues from West Yorkshire and Harrogate Health and Care Partnership on the development of this review.

The spread and adoption of innovation is a key part of our work at the AHSN and this has created an opportunity to identify and champion some of the excellent work across our region.

The AHSN is committed to supporting West Yorkshire and Harrogate Health and Care Partnership in the delivery of their Five-Year Plan and will work in partnership to develop projects, programmes and initiatives that reflect local challenges.

> As part of a national network, we are in a unique position to both bring shared learning from across the country, and internationally, back to support our local partners and champion the excellent projects and initiatives currently being delivered locally.

The case studies outlined in this document provide an example of how West Yorkshire and Harrogate Health and Care Partnership continue to drive forward innovation and new ways of working. The local case studies have emphasized how well-designed and person-centred housing support initiatives have a direct positive impact on people's health and wellbeing. If we want to reduce the health inequalities across our region, we cannot ignore the psychological, emotional and physical impact of poor housing on people's lives and wellbeing.

Investment in quality housing and targeted support is an important tool in reducing the gap in health inequalities and will help lessen the financial burden on health and social care resources. Partnership work across sectors including housing, health and social care and voluntary organisations is fundamental if we want to find sustainable solutions in the long-term that will release pressure on NHS services and wider public services.

A well-housed population helps to reduce and delay demand for NHS services and helps patients to be discharged when they are ready to go in an environment that can help their recovery and allow them to live independently for longer.

This report will support colleagues across the Yorkshire and Harrogate Health and Care Partnership and the excellent work already started across the region to unlock the potential of housing for health. We are looking forward to building on this to tackle some of the health inequalities across the Yorkshire and Humber geography.

Literature Review

Introduction

This new report and the work undertaken to gather the supporting information within, was prepared and developed prior to COVID-19. Unfortunately, as a direct result of the Covid-19 pandemic, the publication and launch of the report was delayed until October 2020.

The pandemic has resulted in a significant impact on the housing sector. In August 2020, the Health Foundation reported that the impact of housing on health is likely to have been greater than ever during the lockdown period. They reference research published by the National Housing Federation from June 2020 which indicates 31% of Adults in the UK had experienced mental or physical health problems linked to the condition of their home or their lack of space.

Furthermore, the recent publication "Homes, Health and Covid-19" by the Centre for Ageing Better and The King's Fund (September 2020) highlights around one in five excess deaths during winter are attributed to cold housing. It goes on to report that should social distancing measures continue through winter, the impact of fuel poverty on both physical and mental health could potentially escalate and that spending extended periods exposed to damp or mouldy conditions is "likely to exacerbate or induce respiratory and cardiovascular conditions, in turn increasing the risk of contracting COVID-19"

The same report highlights the significant impact of overcrowding and the associated, increased risk of viral transmission. The report by the Health Foundation reaffirms the importance of reducing overcrowding, and mitigating housing insecurity to help meet the health needs of our population in the years to come. Research by Shelter produced in June 2020 indicates the UK can expect to see 218,000 fewer homes being built over the next five years in comparison to Government targets prior to the pandemic and 4,600 fewer homes for social rent.

It is well-established that conditions for housing have a considerable impact on the health and wellbeing of individuals and a direct financial impact on local health and care systems. A paper by the Building Research Establishment (BRE 2015) made a conservative estimate that the cost to the NHS alone was around £1.4bn in 2015, a considerable rise from the £600m in its 2010 report. Furthermore, the Audit Commission (2009) suggests that for every £1 invested in housing, £2 of costs are avoided to public services, including health and social care. The relationship between homes and wellbeing is a complex one, the route from home to health and back again is intricately placed in a web of other factors, and, as Garnham and Rolfe (2019) suggest, 'home' is never just a physical shelter, but 'a foundation for social, psychological and cultural wellbeing.' This literature review considers the evidence available for the impact of housing initiatives to areas of specific interest to West Yorkshire and Harrogate, highlighting where and how investing in housing could have considerable savings on health and social care budgets.

Housing Initiatives: A definition

For the purposes of this report, we define a housing initiative as any collaborative programme that aims to address the housing needs of people who are at risk of living in an unhealthy home or require support to live healthy and independent lives in a good home.

An 'unhealthy' home, by contrast, fails to meet one or more of these basic criteria. Across West Yorkshire and Harrogate, we recognise the conditions for a good home environment go beyond the physical accommodation and include all the conditions necessary to sustain an independent and healthy life. This can include, family, community, social connections and the kind of support that helps people to remain independent.

Well-established definitions of a healthy or 'decent home' state that it must*;

a) meet the current statutory minimum standard for housing
b) be in a reasonable state of repair
c) have reasonably modern facilities and services
d) be able to maintain a reasonable temperature

(Department for Communities and Local Government 2006)

**For further detailed definitions of an unhealthy home, the government (Housing Act 2004) uses the housing health and safety rating system (HHSRS) to assess 29 categories of housing hazards, weighting them as Category 1 (serious) or Category 2 (other).*

Current National Housing Challenges

The housing sector in England is diversely represented by private and social landlords (such as housing associations), as well as privately owned homes and developments. According to the National Audit Office (2017), 20% of homes were privately rented in 2017 and 17% were socially rented.

The English Housing Survey (EHS 2017) states in its headline report that in 2017 11% of housing stock included a Category 1 HHSRS hazard, more prevalent in the private rental sector than in social housing. The report also states that **897,000 homes (4% overall) had problems with damp**, and **746,000 homes (3% overall) were overcrowded**, with figures rising in both the private and social rental sectors.

Current National Homelessness Challenges

Meanwhile, homelessness figures suggest that between October to December 2018, **61,410 households were assessed as statutory homeless** (Ministry of Housing, Communities and Local Government 2019a). This figure is a conservative estimate of the amount of people affected by homelessness, for example the number almost doubles when including those who seek but are denied statutory homelessness (Ministry of Housing, Communities and Local Government 2019) and it is furthermore impossible to accurately estimate the 'hidden homeless' (e.g. those who sofa surf).

In a 2017 policy briefing by the University of Sheffield, West Yorkshire Finding Independence (WY-FI) et al., it is stated that homelessness often happens at the later stages of a sequence of events that can include poverty, trauma and abuse. This is often predictable but people with multiple complex needs can be reluctant to engage with services for diverse reasons, such as previous negative experiences or reluctance to share personal information. It is proposed that support from services should be responsive, flexible and reflect the 'goals and aspirations' of the individual rather than service requirements.

Tenancy sustainability is also widely recognised as an important factor in preventing a decline in health with a particular focus on avoiding mental ill-health. Whilst tenancy sustainability may be interpreted differently by different organisations or bodies (Chartered Institute of Housing, 2014), it has a potentially important contribution to preventing homelessness.

The impact on health

The impact of an unhealthy home is evident right from childhood. A report from Shelter (2006) states that **poor housing conditions increase the risk of severe ill-health and disability by 25% in childhood and early adulthood**. Specifically, children in bad housing are **ten times more likely to contract meningitis**. Children in **overcrowded housing are more likely to contract tuberculosis (TB) and respiratory problems, such as asthma**, as well as slow-growth, which can be linked later in life to coronary heart disease. Finally, children in bad housing are more **likely to have behavioural problems**, such as aggression, hyperactivity and impulsivity. Further research from Shelter (2006) suggests that homeless children are **three to four times more likely to suffer from mental illness**, with similar trends for those in poor and overcrowded housing. The World Health Organisation (WHO 2018) also assesses that overcrowded houses poses a 'high' risk generally of contracting TB and a 'moderate to high' risk of contracting other respiratory illnesses in adults. Meanwhile, research carried out by Shelter and Comres (2017) found a direct link between housing and mental wellbeing, most specifically anxiety and depression. **20% of the sample population questioned stated that they had a housing problem or worry within the last five years, which they identified as having a negative impact on their mental health.**

There are numerous examples of how housing initiatives impact positively on the provision of health services. In a review published in 2017 of evidence on the benefits of supported housing for older people, DEMOS reports that the older generation who lived in sheltered housing (as opposed to older general population) spent nine fewer nights in hospital for unplanned admissions. They state:

> "One of the reasons for the relative brevity of sheltered housing tenants' time in hospital is the fact that they can more easily integrate back into appropriate and accessible housing with an element of support already present."

The report by DEMOS goes on to quantify the impact of sheltered housing as:

- Reduced inpatient stays
- Reduced immediate care costs of falls prevented
- Reduced health and care costs of hip fractures prevented
- Reduced health service use by reducing loneliness

The reviewers conclude that, when combined with qualitative findings in the evidence base, this demonstrates the significant social value of sheltered housing to the tenants, the NHS, social care and the emergency services.

Prevention and Early Intervention

Public Health England has put prevention at the heart of the Long Term Plan (PHE 2018). There is a growing body of evidence to suggest that money invested through housing initiatives will help meet prevention targets. The latest briefing paper from the BRE (2015) suggests that the estimated full cost to the NHS of all homes with significant HHSRS hazards in England is £2bn in first year treatment costs. Treating children and young people injured by accidents in the home costs Accident and Emergency departments across the United Kingdom around £146 million a year (Local Government Association 2019).

The Audit Commission (2009), meanwhile, suggests that **spending between £2000 and £20,000 on home adaptations to enable elderly people to remain at home can save £6000 a year in care costs**. One initiative in the North East – the Gentoo and Sunderland CCG 'Boiler on Prescription' trial – involved GPs 'prescribing' boiler installation and double glazing, resulting in a 28% reduction in GP appointments after 18 months and a 33% reduction in outpatient appointments (Gentoo 2016).

Health Inequalities

Public Health England (PHE 2017) states that health inequalities can be defined as differences in health between groups of people that could be considered unfair. Significantly, it suggests that those living in the most deprived areas can expect to spend 20 fewer years in good health than those in the least deprived areas.

A breakdown of the statistics using PHE's Health Inequalities Dashboard shows that inequalities in life expectancy have widened (PHE 2019). Over 60% of higher mortality rates in the least deprived areas were due to circulatory disease, cancer and respiratory disease. As we have already identified, those living in unhealthy homes are more likely to suffer respiratory and circulatory diseases. Targeting the unhealthy homes which are a contributory factor for these diseases will work towards reducing the inequalities in life expectancy.

Personalised Care

Personalised care is one of the five major changes outlined in the Long Term Plan (NHS 2019), which aims to deliver a 'whole-system approach', integrating services around the individual, including health and social care. Integrating housing and healthcare meets the aims of the five year plan by its joined-up approach to delivering health goals and meeting the individual needs.

The Healthy Homes project in Liverpool (NICE 2017) is an example of a collaborative housing initiative that saw considerable financial impact on health and social care budgets. During the project, Liverpool City Council and the former Liverpool Primary Care Trust joined forces to create a central hub, known as the LHHP, to link up housing and health services, resulting in a targeted prevention of 100 deaths and 1000 GP referrals, with a net saving of £238,000 for a population of 470,000. The report suggests that the impact is also on secondary care from preventable chronic diseases.

Wider determinants of health and wellbeing

Public Health England (2018) identifies housing as one of the significant determinants of health and wellbeing, stating that in England, most people spend a significant proportion of time in their home environment.

The Marmot Review (2010) makes policy recommendations including a repeated call for full integration of planning, transport, housing, environmental and health systems to address the social determinants of health in a locality. The King's Fund report Housing and Health (2018) further highlights the opportunity for STPs and ICSs to address the economic and social determinants of health through a focus on good housing.

Mental illness is closely associated with inequalities including poverty, unemployment and homelessness according to PHEs 'Health Matters' resource (2018). 'Good-quality, affordable and safe housing is a vital component in good mental health, as well as supporting those with existing mental health conditions,' according to The Mental Health Foundation.

Health inequalities can be widened, and additional inequalities created, once people reach old age, again influenced by social, economic and environmental determinants. **Around 34% of older people in England live in non-decent homes** and living in a cold home is a predictor of poor mental and physical health (BMA, 2016).

The Joseph Rowntree Foundation (2017) warns that significant falls in poverty over the past 20 years amongst children and pensioners are at risk of reversal. Factors explaining this include rising rents, less help for low income renters and falling home ownership leaving more people struggling to meet the cost of housing.

The impact of housing on health and wellbeing is clear and making new homes healthier places to live is increasingly recognised by planners and, to a lesser extent, developers. In a briefing note the UK Green Building Council (2018) uses the results of a survey of 450 home-owners and tenants to highlight the importance of natural light, adequate room size to allow social interaction, such as eating as a family, and year-round thermal comfort. But perhaps the key points relate to community, amenities and connectivity – a good location, a feeling of security, good transport links and green spaces which in turn support activity and create a healthy environment.

A lack of affordable, appropriately-adapted housing may force older and disabled people to move away from their social networks, leading to social isolation and loneliness according to a Scottish Government consultation analysis (2018), which in turn has significant effects on mental and physical wellbeing. People experiencing homelessness are heavy users of health services for mental and physical health issues but are often in a cycle of debt, poverty and unemployment. Homeless Link (2019) calls for joined up health and housing as part of the solution.

West Yorkshire and Harrogate – a local picture

West Yorkshire and Harrogate has a diverse population providing care and support to around 2.7 million people. The partnership has a collective budget of over £5.5bn and has a workforce of over 100,000 people including health and social care workers and is made up of a number of different partners including thousands of voluntary and community organisations and hundreds of independent care providers.

Across West Yorkshire and Harrogate there is a combined total of 60 Registered Social Landlords. Collectively they provide over 110,000 homes across general need (93k), supported housing (5k), older persons (8.5k) and shared ownership (3.4k) (Regulator of Social Housing, 2019).

Despite the support provided by Social Housing, the geography still has high levels of homelessness across the region. In 2018, a report undertaken by Shelter identified across West Yorkshire and Harrogate estimated almost 1500 people were either homeless in temporary accommodation or rough sleeping, with Wakefield having the highest prevalence of homelessness where one in 862 people are currently homeless (Table x, below)

Authority	Homeless in Temporary Acc	Rough Sleeping	Total people homeless	Population	Rate (1 in x)
Wakefield	388	7	395	340,790	862
Bradford	496	15	511	534,800	1,047
Harrogate	118	6	124	160,044	1,286
Kirklees	255	8	263	437,145	1,665
Calderdale	46	6	52	209,454	4,000
Craven	13	1	14	56,604	4,009
Leeds	61	28	89	784,846	8,794

Table X, Prevalence of Homelessness across West Yorkshire and Harrogate, Shelter 2018

Employment across the region is in line with the national average at 3.9% (Office for National Statistics, 2020) with over 53,000 unemployed people and over 122,000 workless households (16.4%).

West Yorkshire and Harrogate Totals / Averages	Total
Number Of Workless Households	122,200
Percentage Of Households That Are Workless	16.42%
Unemployed People	53,500
Unemployed as a percentage	3.9%

Table Z, Office for National Statistics 2020

Our challenges across the wider determinants of health are reflected in our health inequalities across the region. The Index of Multiple Deprivation 2015 shows that Leeds, Bradford, Calderdale and Kirklees all have deprivation scores higher than the National Average and our life expectancy (male and female) is lower than benchmarked comparators for the above places also.

	Bradford	Calderdale	Craven	Harrogate	Kirklees	Leeds	Wakefield
Life expectancy at birth (male)	77.8	78.3	81.1	81.0	78.5	78.3	78.3
Life expectancy at birth (female)	81.6	82.2	85	84.6	82.5	82.1	81.9
Under 75 mortality rate from all causes	406	375	259	279	365	381	383
Under 75 mortality rate from all cardiovascular diseases	105.0	91.9	51.3	59.0	83.0	86.3	87.0
Under 75 mortality rate from cancer	145.6	142.0	109.7	120.0	141.2	147.5	144.0
Suicide rate	8.8	12.5	12.4	13.2	10.3	10.9	10.9

Key	Better	Similar	Worse	Not Compared

Source: Public Health England, Local Authority Health Profiles 2020

Conclusion

Not only is it a clear government message that housing must be at the heart of a personalised service, the (relatively few) studies considered here suggest that investment in quality housing and targeted support is one important tool in reducing the gap in health inequalities. Further case studies have been highlighted in the appendix to suggest this is a wider trend.

The expansion of the private rental sector in the last 20 years, coupled with the statistics suggesting that this sector has the highest proportion of housing failing to meet the decent standard (Ministry of Housing, Communities and Local Government 2019b) indicates that investment in housing initiatives targeting this sector in particular could have a significant impact on health and social care outcomes.

Regardless of which housing sector an initiative targets, however, the literature overall strongly indicates that investment in collaborative housing initiatives will lessen the financial burden on health and social care resources.

Case Studies

The following section of our report collates a series of case studies demonstrating the positive impact of successful housing initiatives and programmes can have on health and health outcomes for our population. Each case study is taken from across the West Yorkshire and Harrogate footprint and, whilst it is not an exhaustive list of all the on-going programmes of work, it provides positive insights into the excellent work that has been undertaken to date and continues to demonstrate a positive impact on the lives of people across West Yorkshire and Harrogate.

The case studies are themed into the following areas:

1. Fuel Poverty & Warm Homes
2. Supporting Discharge inc Aids & Adaptations
3. Social Prescribing
4. Financial Inclusion
5. Homelessness
6. Domestic Violence
7. Ageing Well
8. Learning Disability
9. Mental Health

	Case Study	Theme	Location	Summary
1	Home Energy Efficiency Programme	Fuel Poverty and Warm Homes	Wakefield	A proactive programme to support residents to stay healthy and warm in their homes.
2	Financial Assist with housing repairs	Fuel Poverty and Warm Homes	Bradford	Targeted financial assistance for vulnerable owner occupiers to make essential repairs to their property.
3	Home Plus	Fuel Poverty and Warm Homes	Leeds	Support service to enable independent living by improving health at home, helping to prevent falls and improving health conditions.
4	Heatherstones Court	Supporting Hospital Discharge (Including Aids and Adaptations)	Calderdale	A 'home from home' setting to progress patient health and confidence moving back into the community after a long hospital stay.
5	Home from Home Service	Fuel Poverty and Warm Homes	Kirklees	Support to enable individuals to regain their independence in a safe, suitable and supportive environment.
6	Accessible Homes Team	Supporting Hospital Discharge (Including Aids and Adaptations)	Kirklees	Expertise and support for people with disabilities who are experiencing difficulty because of the layout/design of their homes.
7	Telecare/Care Link Alarm System	Supporting Hospital Discharge (Including Aids and Adaptations)	Wakefield	24 hour response service to people in their own home who have recently been discharged from hospital and people at risk of a fall.
8	Housing Support and Coordination (Hospital Wards)	Supporting Hospital Discharge (Including Aids and Adaptations)	Wakefield	Support provided on wards to anticipate the housing needs of in-patients to reduce delays when discharge is appropriate.
9	Disabled Facility Grants	Supporting Hospital Discharge (Including Aids and Adaptations)	Bradford	Funding towards the cost of making changes to a person's home so they can continue to live there if they become disabled or their disability changes.
10	Accommodation Gateway	Supporting Hospital Discharge (Including Aids and Adaptations)	Leeds	Assistance for those leaving hospital after a mental health in-patient stay by supporting them find the right home.

	Case Study	Theme	Location	Summary
11	Health and Housing - Discretionary Funding	Supporting Hospital Discharge (Including Aids and Adaptations)	Leeds	Funding to help support disabled and vulnerable residents to maintain independent living in a safe home environment.
12	Kirklees Neighbourhood Housing - Tenant Involvement	Social Prescribing	Kirklees	Community outreach programme designed to improve the wellbeing of local communities.
13	Retirement LIFE	Social Prescribing	Leeds	Supporting tenants to live in their own home and address social isolation.
14	Money Smart	Financial Inclusion	Wakefield	Free package of assistance to support households to save money and maximise income to alleviate fuel poverty and wider poverty.
15	Cashwise	Financial Inclusion	Wakefield	Support service providing financial and administrative advice to enable people to manage their money and sustain a tenancy long-term.
16	West Yorkshire Finding Independence	Homelessness	West Yorkshire	Support system for those experiencing multiple and complex needs to achieve their personal goals and aspirations.
17	Engage Leeds	Homelessness	Leeds	City-wide housing support service to prevent anyone losing their home and to support independent living.
18	Sanctuary	Domestic Violence	Kirklees	Emotional and practical support system for those experiencing domestic abuse to remain safely in their home.
19	Activage	Healthy Ageing	Leeds	Pilot in association with Samsung to provide technology to support better ageing, maintain independence and improve communication.
20	Extra Care Housing	Supporting Hospital Discharge (Including Aids and Adaptations)	Kirklees	Specialist housing scheme providing extra facilities to support independent and flexible living as an individual's care need changes.
21	Shared Lives	Learning Disability	North Yorkshire	Social support system for those with learning disabilities to live independently within a family-style support network.
22	Mental Health Navigators	Mental Health	Wakefield	Early intervention programme to support those with mild/moderate mental health issues to live independently.

Airedale Wharfedale and Craven

Craven District Council
North Yorkshire County Council

16	WY Finding Independence	West Yorkshire

Bradford

Bradford District Council

9	Disabled Facilities Grant	Bradford
2	Financial Assist w Housing Repairs	Bradford

Calderdale

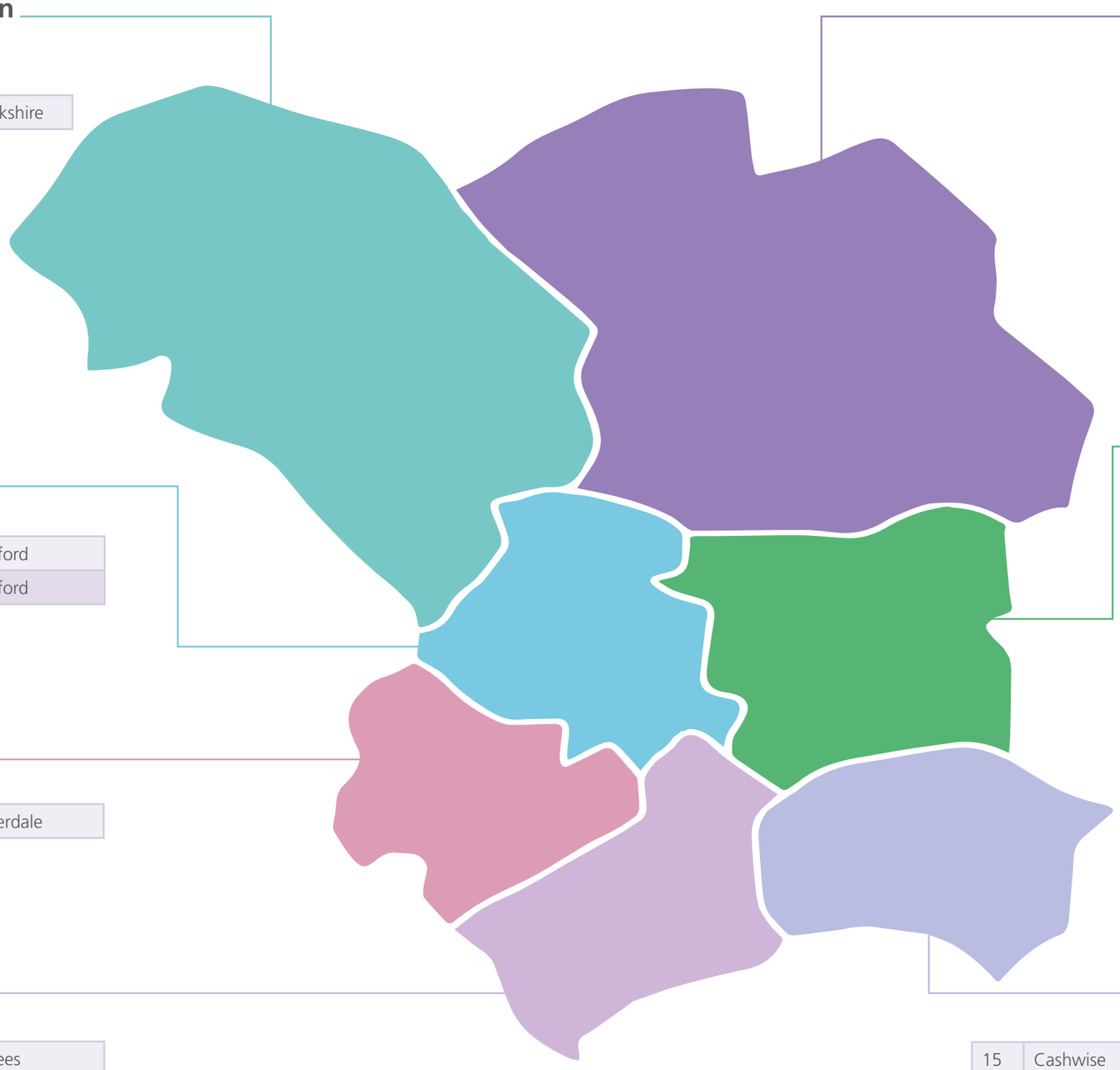
Calderdale Council

4	Heatherstones Court	Calderdale

Kirklees

Kirklees Council

12	Kirklees Neighbourhood Housing	Kirklees
19	Sanctuary	Kirklees
6	Accessible Homes Scheme	Kirklees
5	Home From Home Scheme	Kirklees
20	Extra Care	Kirklees



The Impact of Housing on Health: **Case Studies**

Harrogate

Harrogate Borough Council
North Yorkshire County Council

21	Shared Lives	North Yorkshire

Leeds

Leeds City Council

3	Home Plus Service	Leeds
19	Active Age	Leeds
17	Engage Leeds	Leeds
13	Retirement Life	Leeds
11	Health and Housing – Discretionary Funding	Leeds
10	Accommodation Gateway	Leeds

Wakefield

Wakefield Council

15	Cashwise	Wakefield
14	Moneysmart	Wakefield
8	Housing Support and Coordination (Hospital Ward)	Wakefield
1	Home Energy Efficiency Programme	Wakefield
7	Telecare - Care Link Alarm System in Wakefield	Wakefield
22	Mental Health Navigators	Wakefield

1. Home Energy Efficiency Programme

A comprehensive, proactive programme by Wakefield Council to support residents to stay healthy and warm in their homes.

Case Study Theme:
Fuel Poverty and Warm Homes

Location: **WAKEFIELD**

Summary

The **Home Energy Efficiency Programme** supports vulnerable, fuel-poor households by installing improved heating and insulation. Grant aid provides the new systems free of charge, or at a reduced charge and the Council coordinates installation through its approved contractors.

Eligibility uses fuel poverty proxy criteria including:

- Household income below £21k
- Cold-related illness
- Poor household energy efficiency

Schemes vary depending on funding and strategic objectives. A recent scheme supported eligible households in Castleford to install external wall insulation (EWI) and other efficiency measures.

Social Impact

Assessment of income/fuel bills/energy efficiency is used to monitor impact. The Castleford EWI scheme improved properties from a SAP 59 to 68. The Fuel Poverty Fund scheme improved properties from SAP 58 to 65. SAP is a score of energy efficiency (1-100) and the significant increases would clearly indicate warmer homes that cost much less to heat and save money on fuel bills.

Health Impact

A quantitative health impact assessment report in 2016 concludes that cold homes in Wakefield cost the NHS £800k each year and that the wider cost to the public purse is at least £2m each year.

Health impact and wellbeing assessments are carried out before and after intervention and repeated 12 months later. Early results show positive feedback from individuals with warmer homes and the longer term data capture will provide the continued return on investment figures.

Financial Summary

Cost varies from scheme to scheme e.g. the Castleford external wall insulation scheme cost £900k and supported 86 households.

The scheme is delivered and coordinated using existing Council staff resources in the Strategic Housing Energy Team.

Internal funding is allocated on an annual basis, currently £200k for 2019/20. External funding bids are submitted and Better Care Funding is currently being sought.

Approach / Methodology

Since 2001 the Wakefield Fuel Poverty Partnership involving health and social care organisations, Public Health, utility companies, third sector, Groundwork and Department for Work and Pension among many other stakeholders have worked together to tackle fuel poverty and oversee the Wakefield Affordable Warmth Charter through delivering proactive support schemes to combat fuel poverty.

Key barriers and challenges include:

- Single year allocations make long-term planning difficult
- Bidding for external funds requires time and capacity
- Rolling programme of overlapping projects means that evaluation can be subsumed by new initiatives
- Cost of marketing to target individuals in need is high

Key learning

- Learning is ongoing with each project through monitoring and evaluation
- To achieve significant benefits, the most effective way to promote the scheme is by targeting an area with low income households/high population of older people
- Knocking on doors and engaging directly with residents is the best way to find people in need of support and build trust
- A 'one door' approach is applied through the delivery of home energy efficiency support so that whatever issue a resident contacts the Council for, they can be made aware of the support available for home energy efficiency

A key ambition for the programme is longer-term, sustained funding on a multi-year basis.

2. Financial Assistance with Housing Repairs

A Bradford City Council programme that offers targeted financial assistance for vulnerable owner occupiers to make essential repairs to their properties.

Case Study Theme:
Fuel Poverty and Warm Homes

Location: **BRADFORD**

Summary

The City of Bradford MDC provides financial assistance with housing repairs to address hazards in privately owned, owner/ occupied properties caused by disrepair or defects. The financial assistance is delivered through equity loans or small grants. Loans are administered by Sheffield City Council on behalf of Bradford MDC.

The broad aim is to improve health and wellbeing by improving properties, making them safer and removing hazards. It is available across the district to homeowners who meet eligibility criteria related to income. The assistance ensures that people who are vulnerable and have no other access to financial assistance can stay living in their own homes, independently and safely. In particular, this can prevent, or significantly reduce current and future social care and NHS costs in treating conditions exacerbated by cold homes or injuries that occur from falls or hazards. A well maintained home has been shown to significantly increase the likelihood of children meeting their development and educational attainment milestones.

Social Impact

Living in a home without hazards and with good quality facilities is crucially important to maintaining a healthy life, enabling owner occupiers to remain in their home for longer, promoting independence and mental wellbeing. Provision of assistance through equity loans encourages responsible ownership and the improvement of the housing stock contributes to a more sustainable district.

In a linked scheme that ran until 2018, an additional health and lifestyle assessment by a Health Practitioner enabled the practitioner to offer health advice, signposting and referral to other services and organisations. This complemented the housing improvements to provide a holistic response. The impact on the health and wellbeing of the clients was significant, improving independence, mental wellbeing, self-reliance and contribution to the wider community.

Health Impact

Improvement of the home environment and eliminating hazards such as excess cold, damp and mould, risk of falls, unsafe electrics, risk of fire, etc. significantly impacts on the health and wellbeing of the occupants, especially the elderly or young children. Reducing or eliminating the risk of accidents relieves pressure on health services such as GPs and Accident and Emergency and can speed up hospital discharges.

The impact on the mental health of owner occupiers should also not be underestimated as they regain their independence and pride in their home.

People who apply for assistance can then also be signposted to other services provided by local health and welfare partners.

Financial Summary

The programme is supported by the Council's own capital budget, at approximately £1m per year.

Quantifying return on investment (ROI) is difficult but it is known that preventative work to mitigate hazards associated with falls on stairs in households with an adult aged 65+ would cost in the region of £290m but give a wider benefit to the public purse of £470m, which corresponds to an ROI of 62p/£1 and a payback period of less than 8 months.

Approach / Methodology

This assistance is publicised via the Council website, widely distributed leaflets, organisations such as Age UK and targeted mail shots to potentially eligible properties.

Applicants are financially assessed and, if they cannot fund repairs through commercial borrowing, an equity release loan of up to £30,000 is offered. Where applicants are not able to fund repairs using equity, a non repayable grant of up to £5,000 is offered.

Applicants may source their own contractor or use the Council's agency service.

Key learning

- Providing equity loans enables owner occupiers that are 'cash poor / asset rich' to access funding that is not normally available.
- The agency service can be invaluable where applicants cannot source a contractor and manage works themselves.
- For equity loans, applicants must have 'capacity' to understand the product they are signing up to and applicants are encouraged to seek independent financial advice.
- The role of the linked Health Practitioner was significant in maximising the improvements in quality of life, independence, pride, happiness and health.

3. Home Plus

Home Plus in Leeds enables people to maintain independent living through improving health at home, helping to prevent falls and improving health conditions exacerbated by the cold.

Case Study Theme:
Fuel Poverty and Warm Homes

Location: **LEEDS**

Summary

Leeds' Home Plus service addresses health risks in the home, including energy efficiency and affordability, warmth, condensation or damp, and repairs that reduce the risk of falling. The service is delivered through assessing client needs, facilitating minor works or minor warmth measures, and providing advice and assistance including equipment. The service is jointly commissioned by Leeds City Council and Leeds Clinical Commissioning Group and delivered by Care and Repair, Groundwork and Age UK.

Home Plus is available to people who:

- are struggling to heat their home and/or pay fuel bills
- need help with repairs that are causing a hazard in their home
- need practical interventions to enable timely discharge from hospital
- need information or advice to maintain independence
- may be at serious risk of falling.

This help is targeted to people who then also have additional vulnerabilities:

- aged over 65
- during pregnancy or people with dependent children
- living with a long term condition
- increased risk of falling or living with frailty

Social Impact

In first 9 months of the project, 469 people have received rapid response practical interventions such as:

- fitting of rails to enable discharge home from hospital
- maximising income by carrying out benefits checks and assisting with Attendance Allowance applications – with an estimated additional £30k in entitlements secured for residents
- supporting with switching fuel providers to get best tariff
- negotiating with fuel providers to reduce fuel debt

Local contractors were employed. Sharing of expertise and knowledge of staff across the three organisations has been beneficial.

90% of people assisted "feel more confident to contact support agencies and 'help themselves'".

Health Impact

100% of people that were supported by the service felt safer in their home, 97% felt more independent at home, and 86% have an improved sense of wellbeing. More adults and older people helped to live at home – 1,742 people assisted with falls prevention interventions in first 9 months.

Follow-up surveys are being conducted to find out what impact the support provided has had after six months, e.g. fewer/no falls, reduced hospital admissions/ GP visits, reduction in fuel bills, warmer homes.

In a recent evaluation of 39 people who were followed up 6-months after falls prevention measures were implemented:

- 25 had fallen in the home prior to receiving support from Home Plus
- 18 out of the 25 had not fallen in the 6-months post Home Plus
- 37 now feel safer in their home
- 36 now feel more independent
- 26 are using more of their home

Financial Summary

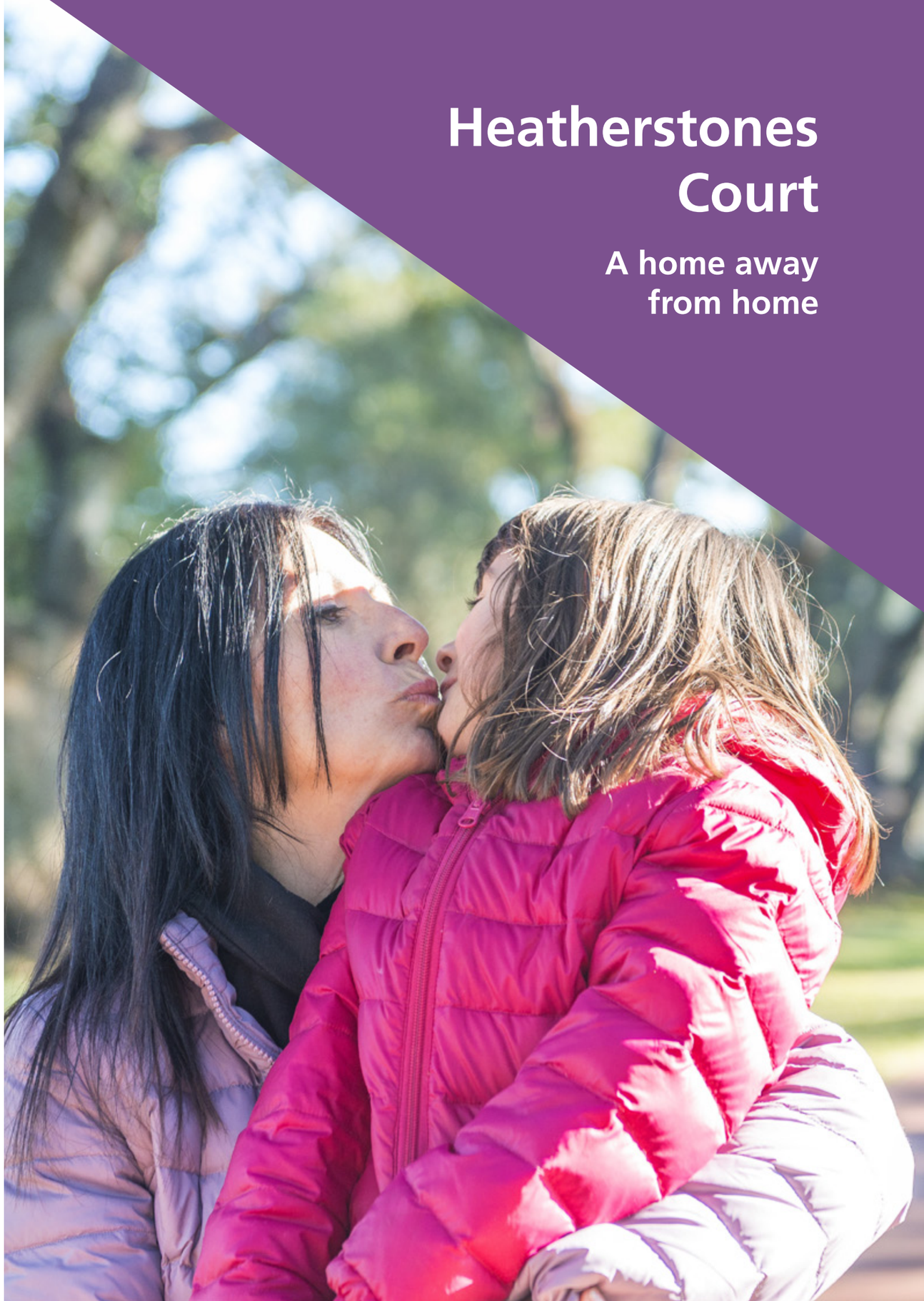
Home Plus is funded by Public Health and Housing Leeds at Leeds City Council. The contract value is £570,367 per annum from Leeds City Council, or £720,367 including the funding contributed by Leeds CCG (until Sept 2021). Follow up surveys will identify some of the cost benefits of putting in place preventative measures.

Approach / Methodology

Leeds City Council conducted an in-depth needs assessment, evidence review and consultation on housing independence and warmth for older people, funding was secured for a new service and a procurement process commenced; 3-month mobilisation with fortnightly meetings and effective communication between commissioners and partnership; setting up NHS secure email address for NHS referrals; communicating new referral criteria/process across the health care system - this service has stricter referral criteria to ensure only those at highest risk/need access the service; communications strategy; single point of access/triage.

Key learning

Combining previously separately funded services into one partnership of three city-wide organisations with a strong track record of service delivery; maximising impact/use of resources/added value; seamless service with less duplication for the service user. The new approach increases opportunities to identify and respond to wider needs, e.g. a referral for falls prevention resulting in improvements to heating systems as well.



Heatherstones Court

A home away from home

4. Heatherstones Court

A "home away from home" setting in Calderdale that enables people to progress in their health and confidence to move back into a community setting after being in hospital, either to their previous home or to more appropriate accommodation.

Summary

Calderdale's Heatherstones Court step up/step down scheme provides accommodation for vulnerable adults of any age who are ready to be discharged from hospital and require additional support and rehabilitation to improve their health, mobility and confidence after a stay in hospital.

12 self-contained apartments provide dedicated support, allowing people to see how they might manage at home, with a care and support package. The service also prevents hospital admissions by allowing adults to 'step up' from the community for short periods of intensive support.

The multidisciplinary team is made up of staff from social care, housing support, reablement, occupational therapy and physical therapy, with in-reach from community-based services. It is free of charge with individuals covering their own general living expenses.

The emphasis is on re-learning skills to improve future independence, supporting people to move into appropriate or adapted homes and reducing the risk of re-admission to hospital.

Partners include Calderdale Council Housing Services and Adult Services, Calderdale and Huddersfield NHS Foundation Trust (CHFT), Calderdale CCG and Connect Housing – the developer and owner of the buildings.

Social Impact

Apprenticeships have been core to Heatherstones Court, both in the construction of the new facility and in care staff now employed, creating new opportunities in the local community. The service created 12 additional roles and opportunities, which have all been filled from the local community.

Case Study Theme:
Supporting Hospital Discharge (Including Aids and Adaptations)

Location: **CALDERDALE**

Health Impact

By offering suitable accommodation, it has enabled people to have choice and control over the adaptations carried out in their home.

By providing people with the opportunity to try out equipment such as stairlifts or learn new skills such as accessing services via the internet it has empowered people to retain or regain their own independence.

Heatherstones Court has had a measurable impact in:

- tackling underlying causes of inequalities in people's health and wellbeing.
- reducing hospital readmissions
- preventing long stays in hospital, supported further by the use of telemedicine on site
- reducing the overall number of long term care placements
- helping people to remain independent for longer and regain independence sooner

Health impact and wellbeing assessments are carried out before and after intervention and repeated 12 months later. Early results show positive feedback from individuals with warmer homes and the longer term data capture will provide the continued return on investment figures.

Financial Summary

Analysis suggests that Heatherstones Court has saved the local health and social care economy approximately £358,766.40, averaging £5,694.70 per person of the 63 people included, over a 22 month period between January 2015 and November 2016.

The Impact of Housing on Health: **Case Studies**

Approach / Methodology

Disused staff accommodation on a CHFT site was brought back into use to address key health and housing issues:

- People at the point of leaving hospital were found to need major adaptations to their home
- People at the point of leaving hospital found to have no suitable home to go to
- Managing empty properties

Barriers included persuading NHS partners that this approach would result in direct savings in the health system.

The project required strong project management with board meetings to ensure partners were on board and challenges were addressed quickly and effectively.

Key learning

- The ambition was to develop a unique service that would ease pressures in the health and care system through regenerating disused properties and therefore partnership working was key to the success of the project.
- Positive impact on the local health and care system, including financial savings
- Research evaluation confirmed that Heatherstones Court is a unique resource for the borough, with a number of positive aspects that delivers a high quality experience for the people that use it.

5. Home From Home Service

Kirklees Home from Home works proactively, with people and partners, to enable individuals to regain their independence in a safe, suitable and supportive environment.

Summary

The Kirklees Council Home from Home service gives individuals an opportunity to be discharged from hospital, residential setting or similar, to accommodation more suitable for rehabilitation and re-gaining independence than their own home may allow. The scheme helps to accelerate discharge times as well as support the individual's confidence, recovery levels and re-adjustment to living at home. The Home from Home scheme utilises Extra Care and Residential Living scheme settings.

To be eligible to occupy a Home from Home flat, the occupant must be ready to leave hospital or residential setting they are currently in but be unable to return to their previous residence. This can be because it is unsuitable, needs to be adapted, requires a deep clean or occasionally due to temporary safeguarding concern. They must either have completed or be willing to complete a housing application for the next stage of their progress.

Social Impact

Over the five years since it began, the scheme has enabled 98 people to regain or retain independence in appropriate accommodation.

The average length of stay is now approximately 8 weeks and as the service has developed it has improved the processes to ensure that the turnaround time between application and moving in is shorter and that the flats are left vacant for a minimal period.

The current cost for Home from Home is £203.77per week. This can usually be claimed through Housing Benefit, however, if someone is already in receipt of this in their existing home, this cannot be claimed on two properties at once. In these instances, the cost of the Home from Home flat is covered by Kirklees Council Adult Social Care services. The individual pays a £13 per week utilities charge.

Case Study Theme:
Fuel Poverty and Warm Homes

Location: **KIRKLEES**

As a comparison, the cost of a residential placement is currently £536.77 per week. Therefore, Home from Home is between £333 and £537 per week cheaper and has shown stronger outcomes in terms of people's independence and confidence.

Health Impact

Home from Home works with people to find the solutions and outcomes that best suit their needs and goals outside of acute settings or residential homes, avoiding unnecessary and debilitating stays in hospital and residential placements.

The service has shown demonstrable outcomes in relation to:

- Reducing length of stay in hospital for individuals
- Improving patient flow in acute settings including timely discharge
- enabling people to maintain their independence

Unanticipated benefits have also been seen in Home to Home occupants reducing loneliness, increasing their social connections and engaging longer term in community activities due to increased awareness of these options from the multi-disciplinary team.

Financial Summary

The total costs to Kirklees Council Adult Services in 2018/19 was £38,801. This largely covers the costs incurred when the flats are empty between two occupants. Though, the contributions received from the weekly service charge to occupants, reduced this amount to £19,391 in 2018/19.

However, this does not include the staff costs for coordination of the service.

The Impact of Housing on Health: **Case Studies**

Approach / Methodology

The service is focussed on enabling people to move into independence, rather than the provision of temporary accommodation.

Individuals have an allocated Supported Housing Assessor who helps them to identify at all their housing options if they cannot go back to their own home, for example, helping them to bid for properties.

One initial challenge was the length of stay within the Home from Home flats, to ensure the scheme was financially viable. There is now an escalation structure in place to ensure timely transfers.

Key roles to ensure success are: Supported Housing Assessors, Senior Medical Housing Officer and the multi-disciplinary steering group.

Key learning

Initially, because Home from Home had very little coordination capacity, there were long gaps between occupants, which resulted in a higher charge than predicted for Kirklees Council Adult Services.

Therefore, key to success was incorporating it into the role of the supported housing assessors and the focus of the multi-disciplinary steering group.

6. Accessible Homes Team

The Accessible Homes Team provides expertise and support to people with disabilities who are experiencing difficulty due to the design and layout of their home.

Case Study Theme:
Supporting Hospital Discharge (Including Aids and Adaptations)

Location: **KIRKLEES**

Summary

Hosted by Kirklees Council, the Accessible Homes Team is an integrated service comprising of Social Care workers, Health Service Community Occupational Therapists, Housing technical and support staff. The team provides a tenure (and age) neutral approach to anyone having difficulties in their home as a result of disability – providing an equitable service to all residents of Kirklees regardless of their housing tenure.

Social Impact

Supporting people to retain independence; remaining in their own homes and communities for as long as possible. The approach is person-centred, offering service tailored to the needs of the person and working with them to support in the best way possible, including bidding on the housing register for those who cannot bid themselves – an average of 45 people per month were supported to do this in 2018/19.

- 2393 adaptations were completed in 2018/19.
- Adaptations aren't appropriate for all, some are ineligible due to means testing but support is still offered. In 2018/19 2960 assessments were completed where an adaptation wasn't installed; 467 people were given advice; 630 people were supported with equipment only (including Assistive Technology); 225 people were recommended for re-housing and a further 57 were referred onto other services.

Health Impact

The medical rehousing team supports individuals to move to a more suitable home due to health needs, should other avenues be exhausted or there is a high priority need.

On average the team receives 229 cases per month to assess and in 2018/19 25% of all new lets went to someone with a medical banding.

Financial Summary

In 18/19 the total cost of adaptations provided for all tenures across the district was £4,727,432. This is from Disabled Facilities Grant (DFG) funding via the Better Care Fund and from other council resources (e.g. Housing Revenue Account). Return on investment is difficult to estimate: should equipment or adaptions have not been installed, additional costs could be incurred in a combination of social care, health, mental health and other services.

In 2017, a project looked at individuals receiving 'double-up paid care' and how equipment/adaptations could reduce their care package. One example was an individual originally requiring 37.83 hours of care reduced to only 19.92 hours, an annual saving of £14,749.80. This practice is now on-going and standardised.

An integrated working group including Accessible Homes reviewed the emptying process for chemical commodes. The project used a strengths-based approach with service users, predominantly looking at adaptations or care packages to negate the need for the weekly emptying service. This resulted in people dependent on the service reducing from 120 to 20; a more dignified approach to their toileting and the authority's macerator truck no longer being required (£58k saving).

Approach / Methodology

Forming an integrated team involved integrating staff, priorities and systems from Health, Housing and Social Care resulting in a clear set of agreed principles and procedures which customers now find streamlined and easier to understand.

Unifying the culture of staff and partners was a key challenge which was addressed.

A joint budget removes the barriers to approving costs and streamlines the processes, resulting in a quicker turnaround for customers.

Key learning

A unified and integrated team was both the ambition and the key to success and has removed barriers, streamlined the service and removed bureaucracy.

Increased communication is also a key to success; with staff from key partners all managed under one umbrella, working relationships and teamwork have improved. The waiting times for assessments have reduced from 39 to 4 weeks with fewer 'handoffs' between disciplines; resulting in better service for customers. The model has received national recognition.

Care Link

24 hour reassurance at the push of a button

7. Telecare / Care Link Alarm System

Wakefield's Care Link provides 24 hour response service to people in their own home who have recently been discharged from hospital and people at risk of a fall or who have recently fallen.

Summary

Wakefield District Housing's (WDH) Care Link service is a partnership between WDH, Wakefield CCG and Wakefield Metropolitan District Council (WMDC). It is a 24-hour response support service provided free of charge across the district (regardless of tenure) for:

- people undergoing a period of reablement
- for those who have recently fallen
- people who are assessed as being at risk of a fall

Each person is given an alarm and pendant, a key safe is installed and they are provided with the 24/7 Responder Service.

This offer is also extended to patients who are transported home from hospital by the Age UK Hospital to Home service.

Social Impact

Since 2017, Care Link Technology Enabled Care (TEC) services have been provided as part of this project. 322 customers with no previous Care Link services have been given an alarm and pendant and 200 of these also had the Response Service, meaning they were able to access a falls lifting service and have someone on call 24/7 to go out to check on them when required.

Additionally 511 existing Care Link customers have also been given access to the Response Service.

The alarm and pendant give the person reassurance and the means to contact someone for help.

In excess of 1,200 calls have been received including:

- 118 from people who have fallen
- 58 people requiring an ambulance
- 135 calls resulting in the Response Service attending
- 125 customers requesting support or reassurance e.g. calling GP or contacting family or friends.

Case Study Theme:
Supporting Hospital Discharge (Including Aids and Adaptations)

Location: **WAKEFIELD**

Wakefield Council have received CQC recognition (via the CQC feedback report) for their partnership work in delivering 24-hour support post-discharge, plugging the gap between reablement team care visits.

The Adult Social Care Outcomes Framework measures the success of reablement on the proportion of older people maintaining independence at home 91 days after discharge. Since the project began, this figure has increased from 83.1% to 88.8%.

Health Impact

Since the project began, 97 falls incidents have been attended and in 90 of these instances the Responder Service was able to attend and assist the person. If the service had not been in place then an ambulance would have been called for the faller who would have endured a long lie perhaps before being found. In seven instance, this required an ambulance to attend due to injury or illness.

Financial Summary

The average cost of an ambulance call out is £243, preventing the need for an ambulance to attend 90 times saves £21,870.

The cost to the NHS for admission following a fall is on average £6715. Without the Responder Service, people who fall are more likely to be left on the floor for longer before being found, which increases the likelihood they would need to be admitted to hospital, preventing this 90 times equates to a saving of up to £604,350.

The 210 calls for reassurance meant that people did not need to use 111 or attend a doctors appointment equates to up to £3360 and £6300 respectively.

£90,000 investment from Wakefield CCG has been secured to provide two additional responders to expand the existing Response Service and WDH provide the alarm and equipment free of charge.

Approach / Methodology

The project began with Wakefield Council Reablement Service in October 2017 and Reablement Practitioners were trained to install Care Link equipment at the first visit following discharge home.

The project was expanded in December 2017 to include working with Age UK Hospital to Home service.

Key learning

Key to the success of the project was the enthusiasm of partners who recognised the potential benefits for people. It is now a standard part of the Reablement Service.

Providing 24/7 support reduces response times, ambulance calls and the potential for hospital admission or calls to GPs.

The provision of reassurance has shown a positive impact on people's mental wellbeing at a time when they may feel vulnerable.

8. Housing Support and Coordination (Hospital Wards)

A Housing Coordinator working directly on wards at Pinderfields and Fieldhead hospitals in Wakefield provides support for people to identify and discuss their housing issues that means they are not delayed when they are well enough to leave hospital.

Summary

Wakefield District Housing in partnership with Wakefield CCG and South West Yorkshire Partnership NHS Foundation Trust, provides a Housing Coordinator on the wards at both Pinderfields and Fieldhead hospitals. A collaboration with Wakefield CCG, Mid-Yorks Hospitals Trust, SWYPFT and Wakefield Council identified a need to assess patients' home circumstances and environment on admission.

By identifying barriers to discharge/housing needs early in the admission, housing interventions can be undertaken and the potential for delayed discharge reduced. Also, more effective planning for discharge can begin earlier in the patient journey.

The role of Housing Coordinator was initially run in each hospital as a pilot and is being assessed by the number of cases, case studies and length of stay. It is open to any patient with an identified housing need or barrier to discharge due to their home circumstances.

Social Impact

Since the project commenced in April 2018 the Housing Co-ordinators have supported 193 people with an identified housing barrier to discharge. 56 of these were identified as not having suitable accommodation to be discharged to. The Housing Co-ordinators were successful in securing alternative suitable accommodation in order for the person to leave hospital when they were well enough and to continue recovering in a safe home environment.

Case Study Theme:
Supporting Hospital Discharge (Including Aids and Adaptations)

Location: **WAKEFIELD**

Using the assumption that otherwise these 56 people would have remained in hospital for a further 7 days at an average cost of £400 per day, the savings for this cohort amounts to £156,800. Without access to suitable accommodation it could be argued that delays could have been far more than 7 days meaning much greater financial savings and a far better outcome for the people involved.

Health Impact

Before this role existed, housing related barriers were often left with ward staff to address. Given that housing policy changes frequently, and the local landscape for housing solutions and pathways is always evolving, this often impact on staff time and delayed or prevented discharge from hospital.

To ensure that people have continued support following discharge a referral or signposting is made to other services. To date 184 referrals have been made to other services to ensure an effective discharge process and prevent re-admission.

This Housing Coordinator provides an in-house 'expert' with a knowledge of housing availability and solutions, reducing the time health and social care colleagues are tied up with housing issues, and increasing the time they have to focus on independence and coping skills. All of which together help a person leave hospital with confidence.

Financial Summary

Staffing cost is £40,000 for each of the two housing coordinators.

Approach / Methodology

Work between WDH and health partners had identified that a percentage of coded hospital discharge delays were due to a 'housing' issue. Further analysis identified that 'housing' barriers were generally only identified at the point a patient was medically fit and ready for discharge, causing a delay to discharge as housing solutions usually take some time to put in place.

Through tracking typical "patient journeys" it became clear that talking with the person about their home environment on admission gave a much better chance or removing any housing related barriers such as repairs, getting in place wellbeing support or providing support to explore rehousing options.

Key learning

The partnership has received national interest as an area of good practice and been successful in achieving stage two application in the Public Health Practice Evaluation Scheme. Initial feedback is that the work is unique and is potentially a national model of good practice.

In-hospital Housing Coordinators provide several key outcomes for the health and social care system, including more efficient hospital discharge, reduced delays, better community care following a stay in hospital and a greater sense of agency and independence for the person.

Other benefits the role provides are:

- Customers receiving Care Link (Telecare Service) in a timely manner
- Improved support and early intervention for people leaving hospital
- Increased awareness of Independent Living accommodation and the opportunities this can offer

Due to the recognised success of the role, Wakefield's Integrated Care Partnership has recently approved recurrent funding for the post at Fieldhead to continue. The role within Pinderfields Hospital will be evaluated ahead of the pilot ending and the findings will be presented to partners.

9. Disabled Facilities Grants

Bradford Council administers Disabled Facilities Grants that help towards the cost of making changes to a person's home so they can continue to live there if they become disabled or if their disability changes.

Summary

The Bradford Disabled Facilities Grant, in line with legislation, is for people who need to make major necessary adaptations to their home so they can continue to live in it.

This could be, for example to:

- widen doors and install ramps
- improve access to rooms and facilities – e.g. stairlifts or a downstairs bathroom
- provide a heating or cooling system according to need
- adapt heating or lighting controls to make them easier to use

Eligibility criteria are set out in the national legislation and locally, in a shared process between Housing, Adult Services and Children's Services, Occupational Therapists identify and assess clients and Housing administers the grant.

Social Impact

84% of clients receiving a DFG felt the adaptation was beneficial to their quality of life. Living in a suitable home is crucially important to maintaining a healthy life. Adaptations are designed to enable individuals to maintain their independence which, in turn, enables them to maintain or improve their general health and wellbeing, maintain social networks and keep close contact with friends and family.

Health Impact

Adapting the home can increase the usability of the home environment and enable the majority of people to maintain their independence for as long as possible. Adaptations can reduce the risk of falls and other accidents, relieve pressure on Accident and Emergency services, speed up hospital discharge and reduce the need for residential care.

Case Study Theme:
Supporting Hospital Discharge (Including Aids and Adaptations)

Location: **BRADFORD**

Financial Summary

- The council received £4.698m from the Better Care Fund for 2018/19, covering revenue costs for staff to implement the Disabled Facilities Grants and capital costs for adaptation works.
- The Government grant allocation for Disabled Facilities Grants for 2019/20 is £4,527,491.
- Quantifying what the return on that investment is, is difficult but it is estimated that preventative work to mitigate hazards associated with falls on stairs in households with an adult aged 65+ would cost in the region of £290m but give a benefit to society of £470m, which corresponds to a return on investment of 62p/£1 and a payback period of less than 8 months.

Approach / Methodology

- This is a statutory function of the Local Authority. The rules about whether you can get a Disabled Facilities Grant are complicated and set down in law. Local support is in place to help people understand and navigate what they are entitled to.
- Bradford provides a full agency service for people accessing the grant. The agency identifies a contractor to deliver work, manages work on site and pays the contractor. 79% of clients choose to use the agency and 80% of those that did advised they would recommend others to do so.
- Bradford offers clients equity share loans to help client's fund means tested contributions and excess costs over the maximum mandatory grant of £30k.
- Bradford has a framework of contractors to deliver the works delivered through the agency to speed up delivery and ensure quality of works.

Key learning

- Providing a full agency service for clients is welcomed by clients, ensures quality of work and speeds up delivery
- Providing loans for clients to help with means tested contributions and excess costs enables clients to proceed with adaptations

10. Accommodation Gateway

Accommodation Gateway in Leeds supports people to leave hospital after a mental health in-patient stay by getting people into the right housing or the right pathway towards housing for them.

Summary

Commissioners in Leeds City Council in 2015 worked in partnership with Volition (Leeds' third sector mental health representative organisation), Leeds and York Partnership Foundation NHS Trust, Community Links and other mental health supported accommodation providers to develop a new website based system for improving communication and information flow as part of the mental health hospital discharge process.

The scheme supports hospital discharge and opportunities for individuals to either return home or find appropriate accommodation by assessing them under the Homelessness Reduction Act. This initiative is delivered with partners as part of an 'Accommodation Gateway'.

This support is targeted to people who are in an acute medical bed but are prevented from being discharged due to housing related issues.

Social Impact

Increase in trust from people being discharged when they can see evidence of joint working between third sector organisations, the Local Authority and the NHS.

Improved communication between commissioned services, the Local Authority and third sector organisations – bringing better outcomes for both service users and services.

Case Study Theme:
Supporting Hospital Discharge (Including Aids and Adaptations)

Location: **LEEDS**

Health Impact

Improved speed of hospital discharge from acute mental health wards into supported accommodation – by way of faster assessment in response to referrals.

Improved health outcomes regarding recovery – less delay in staying on wards, faster admission into supported housing and/or return to previous accommodation with visiting support.

Financial Summary

Nominal cost - £2640 contribution towards cost of log-on tokens to be used by partner organisations to access the web portal. Officer time to develop the site and for on-going support and development.

Return on investment estimates vary: the average cost of a delayed discharge from an acute hospital bed is estimated at £500-550 per night, more if an out of area placement is involved. Any improvement in discharge decision making and placement to accommodation will generate savings to the local NHS Trust and/or efficiencies in being able to deliver more services.

The Impact of Housing on Health: **Case Studies**

Approach / Methodology

The project involved seven local third sector organisations, Volition, Leeds City Council and Leeds and York Partnership Foundation NHS Trust to improve the exchange of information in the referral of people from acute mental health wards into supported accommodation.

A Mental Health Hospital Discharge Protocol was established in 2010 between the partners. Services are commissioned by Leeds City Council and Leeds CCG.

The Information Governance risks of transferring paper copies of confidential patient information were identified in early 2014.

Since introducing a web-based solution (Sharepoint) on 1st July 2015, the immediate information governance risks have been eliminated by use of electronic transfer of information rather than posting or faxing paper copies of patient risk assessments. Sharepoint has reduced delays in receiving referrals, initial assessments made on the hospital ward by the Gateway Co-ordinators and the accompanying risk assessment document can be instantly uploaded securely, and an email message alert sent to the receiving organisation.

This information can be assessed and an appointment made the same day to see the patient and potentially offer a place in a service. Previously this took at least two or three days.

Overall the project has helped build partnership and joint working between the third sector mental health providers in Leeds and colleagues in Leeds City Council and NHS, whilst delivering improved outcomes for clients through faster assessments and decision making for placement into supported accommodation. The project was shortlisted for innovation in the national Compact Awards in 2016.

Key learning

Initial meetings identified the complexity of governance structures and sign off required. Relationship building between professions is key.

IT expertise reassured NHS colleagues that the web-based system was robust and secure. Ambition to ensure safe and secure information transfer over a web portal was achieved. Meeting service user expectations depends on a consistent message from all professionals across the pathway.

Faster decision making for referrals to support providers enables a faster discharge from hospital wards and associated improvements in recovery time and general wellbeing outcomes.

11. Health and Housing – Discretionary Funding

Health and Housing is a programme of discretionary funding in Leeds that helps and supports disabled and vulnerable residents to maintain independent living in a safe, secure and stable home environment.

Summary

Leeds City Council's Health and Housing service works with a number of partner organisations to support people to live independently in their own homes, including: Adults and Health Directorate, Children's and Families Directorate, Care and Repair (Leeds) Ltd, Energy Unit, St George's Crypt, Turning Lives Around, Leeds and Moortown Furniture and private sector specialist contractors.

Any Leeds resident identified as disabled and/or vulnerable of any age is eligible.

Last year the service approved 88 individual requests from disabled people for financial help to support independent living. As well as supporting a range of initiatives:

- Adaptations and safety measures for charities providing accommodation to vulnerable people
- Heating systems for disabled people through the Health Through Warmth scheme
- Extensions and amenities for disabled people living on Cottingley Springs and Kidacre Street Gypsy and Travellers sites.
- Occupational Therapists in Adults and Children's to maximise value for money
- Handyperson's scheme and Home Improvement Service via Care and Repair (Leeds) for disabled people.
- Extensions for Looked After Children on behalf of Children's and Families Directorate
- Sanctuary scheme for households at risk of domestic violence

Case Study Theme:
Supporting Hospital Discharge (Including Aids and Adaptations)

Location: **LEEDS**

Social Impact

The social impact of the funding programme is based around the ability to reduce isolation through the provision of aids and adaptations that enable residents to live independently in their homes.

Additionally, many of the aids and adaptations implemented support keeping families together, rather than splitting them apart due to additional health needs.

Health Impact

The funding programme supports positive health outcomes, again through the provision of aids and adaptations that allow people to remain living independently in their own home, rather than moving to alternative supported accommodation. This in turn relieves a burden on the health and care system by reducing repeated hospital visits and reducing the need for additional care in the home.

Financial Summary

In 2018/19, the Health and Housing service spent £1.3m on a wide range of discretionary items.

Approach / Methodology

Health and Housing's discretionary aid under the Regulatory Reform Order is based on their flexible policy that allows a wide use of discretion in the use of the funding.

Every decision for funding is put forward on a case by case basis and stands on its own merits. Officers create a 'spend to save' document that is discussed and signed off by a weekly Review Panel and senior management that creates a robust audit trail.

Key learning

Health and Housing's private sector assistance policy has been written in a very open ended manner allowing officers to think creatively around providing housing solutions.

The ambition was to use the funding in an imaginative way so no potential avenues were 'off-limits' in finding those solutions.

The 2018/19 programme was extremely successful and the intention is to follow the same pathway in 2019/20. The discretionary programme of funding has supported a large number of disabled people and has helped them protect their health and maintain their independence in their homes. Many of the individual payments have gone to help people that would have 'slipped through the system' and even though the amounts of money given in some cases were small, they have been incredibly important to each person.

12. Kirklees Neighbourhood Housing – Tenant Involvement

Kirklees Neighbourhood Housing works closely with Tenants' and Residents' Associations as they are led by people who want to improve the area where they live, build community spirit and campaign for changes that improve the wellbeing of everyone who lives in KNH properties.

Summary

Kirklees Neighbourhood Housing (KNH) manages 23,000 tenancies on behalf of Kirklees Council. A key component of that is to work with tenants on what will enable them to be healthy and well.

The Social Investment Fund is one element of its Tenant Involvement Strategy. The fund is open to Tenants' and Residents' Associations (TRAs) across Kirklees.

This helps to fund number of housing based community projects including sports, intergenerational activities, Tai Chi, Moving More Often classes for older people, and weekend clubs for BAME girls.

The work of the TRAs and the activities they run is an important component in reaching out to tenants on all tenures in local communities. And TRAs play a particularly important role in the areas facing most disadvantage.

Social Impact

Activities led by TRAs such as Roberttown Grange Tenant' and Residents' Association bring together people to exercise, socialise and have fun. This reduces isolation and improves health and wellbeing.

Health Impact

The majority of residents attending the Tai Chi classes have arthritis or diabetes and it has helped with general wellbeing. There is evidence that this is an effective form of exercise particularly suitable for older people that:

- Reduces stress
- Improves posture
- Improves balance and general mobility
- Increases muscle strength in the legs.

Falls are a common cause of Accident and Emergency attendance for older people, so any improvement in mobility, balance and posture can be significant. For some participants, it is their only opportunity for exercise.

Case Study Theme:
Social Prescribing

Location: **KIRKLEES**

Financial Summary

The budget for the Social Investment Fund is £38k and is funded through Kirklees Council's Housing Revenue Account. TRA's can apply for grants of up to £2000.

A single figure for return on investment has not been calculated but there is anecdotal evidence from housing officers of fewer falls and lower levels of stress.

Approach / Methodology

KNH grant scheme is aligned with Kirklees Council's Strategic Priorities, which include the importance of developing healthy and independent citizens.

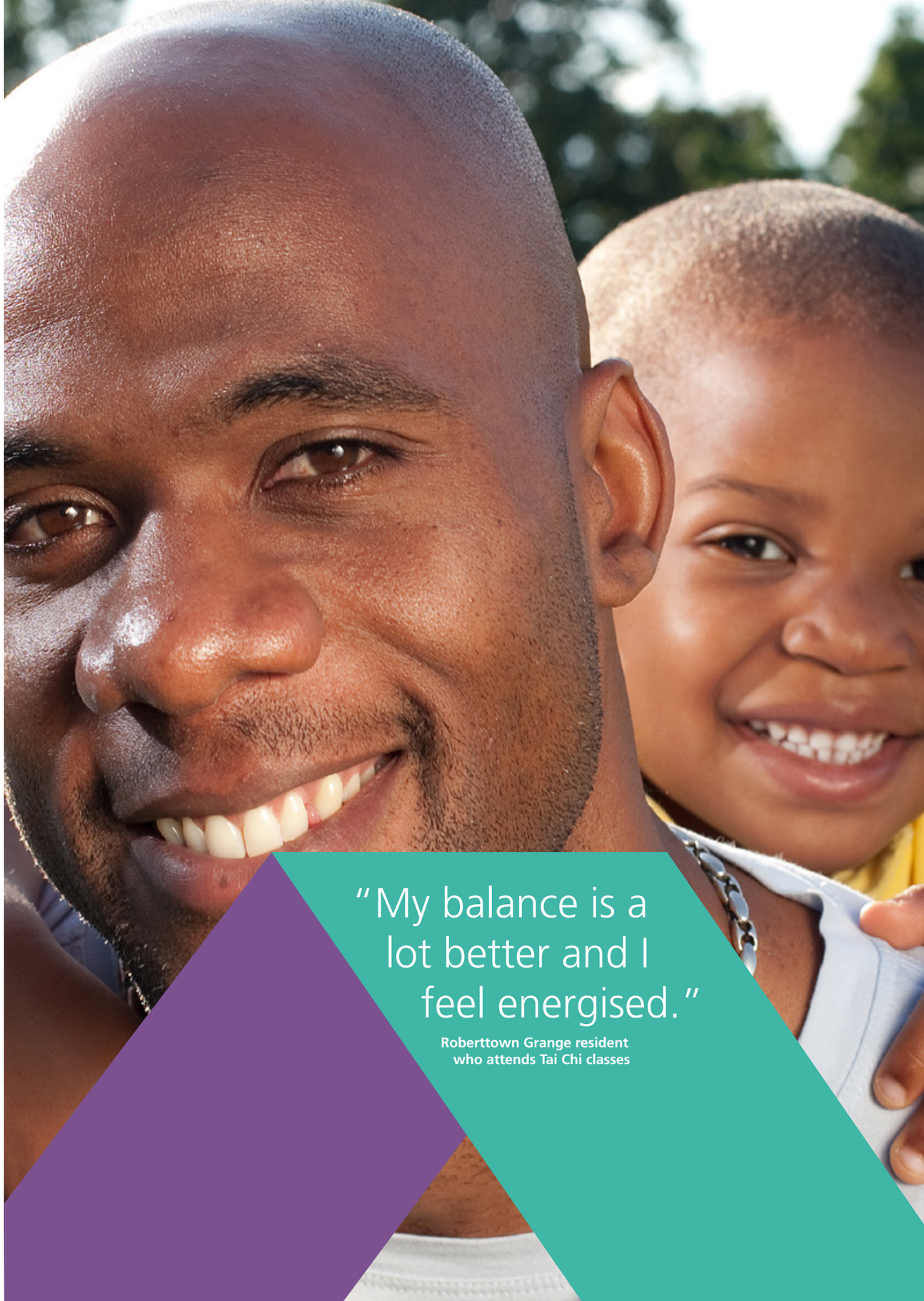
The Social Investment Fund grant promotes these priorities and encourages applicants to focus their projects around these.

Take up of the Tai Chi project was initially slow due to a lack of understanding about what was involved and attendance was consequently low. However sessions are now at full capacity and participants are reporting significant benefits.

Key learning

Many participants have joined KNH groups because they understand the importance of exercise and want to be active but have few opportunities.

Residents who live alone are benefitting from the social interaction the groups offer and forming new friendships, which in turn is reducing loneliness.



13. Retirement LIFE

Retirement LIFE' stands for Living In a Friendly Environment and is the sheltered housing service for Leeds, focussed on support people live independently in their own homes with strong social connections.

Summary

Housing Leeds has rebranded its sheltered housing service to 'Retirement LIFE' (Living In a Friendly Environment). Its focus is on supporting tenants to live independently in their own homes and addressing social isolation.

Support Officers develop and help to deliver social activities at Retirement LIFE schemes with communal facilities.

Those eligible include people living in Housing Leeds LIFE schemes, older people and groups in the wider community.

Social inclusion is a key priority for the Retirement LIFE service and the team continually explores how to develop partnership working to deliver more innovative activities for tenants and older people in the community.

Partners include Neighbourhood Networks, Leeds Let's Get Active, 100% Digital Leeds and Leeds Older People's Forum.

Social Impact

Over 5500 activities take place at 78 schemes across the city each quarter and throughout 2019 there was an increase in tenant led activities.

Almost 1300 activities have a focus on food and nutrition.

iPads have been introduced at a number of schemes and Support Officers have been trained as Digital Champions and are supporting tenants to understand the benefits of technology.

Examples include a tenant who was supported to Skype a friend in Canada who she has not seen for years along with using Google Earth to see where she lived, another made an emergency dentist appointment.

An intergenerational partnership with a primary school has commenced.

Case Study Theme:
Social Prescribing

Location: **LEEDS**

Health Impact

Support Officers have recently been trained to deliver chair based exercise, this has resulted in a GP stating that he had noticed a considerable difference in a tenant's health since she started the chair based exercise class.

Leeds Let's Get Active are a key partner and have supported staff to deliver healthy and active sessions such as bowls, tai chi and table tennis.

Financial Summary

Changes to how the team works have allowed the introduction of quality activities to be within the existing budget.

Approach / Methodology

A key challenge was a lack of confidence initially among the Support Officers, particularly in delivering the exercise classes and with the iPads.

The team have 'buddied' staff together and shadowed other staff who have already had successes. Encouragement to give activities a try and to have fun has had a significant impact.

Key learning

A key success has been the enthusiasm of Support Officers to make a difference.

It is early days but supporting tenants to do more for themselves will have a positive impact on their health and wellbeing, reducing their need to access the health care system.

14. Money Smart

Money Smart provides flexible support to households in Wakefield that maximises income, develops financial skills and resilience, resulting in warmer and safer homes.

Summary

Money Smart began as a pilot by Wakefield Council service and is now being rolled out and mainstreamed across Wakefield District.

It provides a free package of assistance to support households to save money and maximise their income with the aim of alleviating fuel poverty and wider poverty.

All residents of the Wakefield district are eligible but it is aimed at private households and vulnerable low income households are targeted with support.

Social Impact

Much of the data analysis for the people supported through the scheme has yet to be concluded due to the follow-up time lag, however, early proven outcomes for the first 125 people support show:

- Average energy bill savings of £303 each
- Average unclaimed benefit uplift of £1,568 each
- Average annual debt servicing costs of £2,467 reduced through debt management to an average of £83 per person per year

Health Impact

The scheme monitoring does include comprehensive health impact assessments for some people and follow-on data collection is scheduled for 12 months after the intervention for each person.

Financial Summary

Money Smart is coordinated and delivered by 5 full time members of staff and funded from the existing strategic housing team budget, with in-kind support from a range of other partners who are internal and external including the Financial Welfare Team, Adult Education Service and Groundwork Wakefield and LAEP - Local Authorities' Energy Partnership.

Case Study Theme:
Financial Inclusion

Location: **WAKEFIELD**

Approach / Methodology

Money Smart came from a review of how the Council supports people facing fuel poverty which illustrated that a more effective approach would be to deliver comprehensive income maximisation support alongside traditional home energy efficiency improvement measures. This revised approach was in line with local research which indicated that 40% of households in the Wakefield District are classed as being on a low income and as a result low income is the key driver for fuel poverty in the Wakefield District. This is one project in the Council's wider ambition to tackle poverty in Wakefield District.

The scheme is innovative in that it provides a totally flexible support model tailored to the clients' needs. Some clients are supported with brief telephone support for one area of support, whereas the majority are provided with an in-depth 'deep dive' enhanced support service that can take several weeks for multiple strands. The aim is to leave households in a warmer and safer home, in a much better financial position, with the legacy of better financial skills and resilience able to better manage and save their money going forward.

A one-stop-shop provides tailored support on:

- Energy advice / efficiency improvements
- Fuel tariff switching
- Money and debt management advice
- Benefit checks
- Skills and training

Key challenges have been promoting the scheme effectively, revising referral pathways and setting up data collection.

The key influencers to set up Money Smart scheme were the Wakefield Fuel Poverty Partnership who expressed a desire for the holistic and comprehensive fuel poverty and poverty alleviation support service.

Key learning

The ambition was for a successful one year proof of concept and for the scheme to be mainstreamed, which it now has.

Outcome data has yet to emerge but real life case studies demonstrate the positive impact on the health and wellbeing of local people.
The implications for the health and social care of the community from this are that it should be accessed more by health and social partners making referrals for their clients so they can access the benefits in terms of their mental health and general wellbeing.

15. Cashwise

Cash Wise equips people in Wakefield with the skills and confidence to take control of their finances, so they are better able to manage their money and sustain a tenancy long term.

Summary

Support is currently provided to WDH tenants and prospective tenants of all ages via:

- Office based phone support
- One to one home visits
- Digital assistance
- Drop in sessions
- Workshops and community events

With internal and external partners, Cash Wise adopts a person-centred approach to support customers to resolve a wide range of complex financial challenges such as benefit applications and appeals/income maximisation and budgeting/reducing utility bills/accessing grants/setting up priority payments/resolving debts/promoting access to affordable credit/referring to other services where appropriate.

The team has a strong infrastructure including a bespoke Cash Wise case management database and mobile platform which enables the team to record all aspects of the support provided to each customer and is linked to reporting software. To engage and reach a wider demographic, Cash Wise has a dedicated financial inclusion website and the team also uses social media channels to engage with customers.

Social Impact

During 2018/19 Cash Wise supported 1840 vulnerable people plus an additional 1932 referrals related to Universal Credit (UC) between 28 November and March 2019. Throughout this period Cash Wise contacted all customers moving onto UC within a 48-hour window of being notified they were starting their UC journey. The team delivered 55 UC specific drop in sessions across the district to support customers with this transition to the new benefit.

Cash Wise unlocked £1.5 million in unclaimed benefits including disability benefits, accessed £136,000 in grants, made £21,000 of utility savings and supported customers to reduce their debts by £20,000.

Case Study Theme:
Financial Inclusion

Location: **WAKEFIELD**

Health Impact

Health improvements taken as an average for customers supported throughout the year:

- a 50% reduction in stress and anxiety;
- a 50% increase in self-confidence following a resolution of financial challenges;
- 100% increase in a customer's ability to cope with stress and worry linked to money.

Unaddressed financial issues will almost certainly become a drain on the NHS.

Financial Summary

An externally verified SROI calculation for 2018/19 shows every £1 invested in Cash Wise provides a social return of £8.60.

Approach / Methodology

Implemented in 2013 with three years of external funding, Cash Wise was required to demonstrate impact for both WDH and social housing tenants. Initial challenges included:

- Building the confidence of a brand-new service to other internal teams
- Developing the brand and establishing this externally
- Generating referrals both internally and externally
- Raising awareness to wider partner organisations
- The additional service pressures due to welfare reform and poverty
- Putting in place the necessary infrastructure to future-proof the service including a dedicated website, digital referral mechanisms, a financial inclusion database and mobile platform.

The team worked hard to establish Cash Wise and it is now a permanent front-line service.

Key learning

Building a hard-working team of passionate people has been a critical success factor. The ambition was to develop Cash Wise into a well-established support model within Wakefield and this has most definitely been realised. Another ambition was to fully integrate the team within WDH to compliment the other front-line services provided by the business. Cash Wise receives a large amount of its referrals from other internal teams alongside several external partner agencies. In addition, Cash Wise receives self-referrals every week from customers who have heard of Cash Wise and require support. Cash Wise currently receives over 3500 referrals for support each year. All of this is testament to the hard work of the team. Financial challenges are linked to mental ill health, so by addressing these, Cash Wise reduces the strain on local health services.

16. West Yorkshire Finding Independence

The West Yorkshire – Finding Independence (WY-FI) Project strengthens support to people with multiple and complex needs to ensure their effective engagement in services to enable them achieve their personal goals and aspirations.

Summary

WY-FI is a partnership of seven organisations across West Yorkshire including: Humankind (lead partner), Bridge, Barca-Leeds, Community Links, Foundation, Spectrum CIC, and Touchstone. WY-FI supports people who are experiencing entrenched, multiple needs in at least three of the four "HARM" areas: of Homelessness, Addiction to drugs and/or alcohol, Reoffending and Mental ill-health.

The ethos of WY-FI is that these individuals:

- are supported by Multiple Needs Navigators and Specialist Workers who build trusting relationships over time and who are service neutral
- receive person-centred support to achieve their hopes and aspirations
- inform future delivery models and innovation

The ambition is that adults with multiple needs in West Yorkshire should have the opportunity of a settled home from which to build:

- positive health and wellbeing
- access to education and employment
- trust in a positive future

Social Impact

There is a significant impact on services and communities as a result of the lack of effective engagement with people experiencing multiple needs and exclusion, whose pre-existing needs and chaotic circumstances have not been addressed. Services are often being used at the point of crisis meaning effective care cannot be planned and delivered to people experiencing complex needs but also puts added pressure on services in ways which consequently affects the other service users and communities.

Case Study Theme: Homelessness

Location: **WEST YORKSHIRE**

Over 5 years, of 610 people experiencing homelessness:

- 53% have shown a sustained improvement in their ability to manage their tenancy and accommodation
- 50% have shown an improvement in spending their time more meaningfully

By comparing service use in the first year of the project against the second year of the project, and tracking where services and agencies have been involved in the person's life – an average reduction in costs of £5230 per person can be seen.

This includes reduced need for "negative interventions" such as unplanned, acute healthcare, fewer court appointments and reduced need for eviction proceedings. As well as increased "positive interventions" such as engaging with drug and alcohol addiction services and planned physical and mental health outpatient appointments.

Health Impact

96% of WY-FI beneficiaries have coexisting needs around homelessness and mental health and overall 59% of them have shown an improvement in their emotional and mental health. This increases to 69% in the beneficiaries that stay on the programme for at least 2 years.

Additionally, for people with mental health needs:

- 53% improved their relationship with alcohol and drugs
- 44% improved their stress and anxiety levels
- 46% improved their unintentional self-harm score
- 53% improve their physical health

A follow up of those who had left the programme showed that 1 in 3 are maintaining the improvements to their physical health and just over 1 in 10 say their physical health has decreased.

Financial Summary

The Big Lottery Fund has invested £10m in West Yorkshire over 6 years, to improve the lives of people with multiple and complex needs.

Approach / Methodology

WY-FI has been implemented in a period during which the need for the service has grown significantly.

The last decade has witnessed increasing numbers of single people with complex needs and homelessness in all its forms has increased. An recent evaluation report quoted the main challenges as: "growing need, policy changes, the culture of austerity and market-based reforms of public services."

Key learning

A recent evaluation highlights some critical success factors for WY-FI including:

- The quality of the staff
- Low caseloads
- Co-location of the navigator team
- Securing buy-in of key agencies
- Setting up Multi-Agency Review Boards

17. Engage Leeds

Engage Leeds is the city-wide housing support service for Leeds. It aims to prevent anyone losing their home, support people to remain living independently and to enable people to be connected and involved in their local area.

Summary

Engage is a holistic Housing Support Service – aiming to support people who are homeowners, renting or looking for a new home with the barriers that might prevent them from living happily, healthily and independently. Engage supports 1500 adults at any one time and is made up of consortium of 4 partners: Gipsil, Barca, Connect and Riverside.

It focuses on;

- **Prevention** – if people are at risk of losing their home or do not have a home
- **Sustainment** – supporting people to live independently or remain in their current home
- **Integration** – reducing feelings of loneliness or isolation, promoting wellbeing by providing opportunities to get involved in community activities

There is a single point of access for all referrals and that enables a holistic view of the housing-related issues facing individuals, such as money, health, substance misuse, offending behaviour, domestic abuse, work and learning, self-care and harmful behaviour or legal issues.

The Housing Support team is multi-disciplinary including accredited advice workers, welfare benefits specialists, employment advisors, people trained in supporting people with complex needs, dementia as well as staff trained in working in empowering ways, promoting supported volunteering and development of peer support networks.

Case Study Theme: Homelessness

Location: **LEEDS**

Social Impact

Around 3000 clients are successfully supported each year:

- 97% to meet a primary housing need
- 95% to prevent (statutory) homelessness
- 95% to increase their choice, control, involvement and engagement with support networks
- 98% to develop independent living skills

Health Impact

In addition to a housing support need, a large proportion also have a health need. About half have mental health needs, 12% have a physical or sensory disability, 5% have substance misuse issues, 4% are older people with support needs and 4% dementia / memory issues.

Each person has a support plan where they track their own "distance travelled" against a standard set of 49 outcome measures. This shows that on average:

- 56% prevent at least one unnecessary visit to Accident and Emergency 91% better manage their physical health
- 93% better manage their mental health and wellbeing
- 70% supported to cease or reduce their drug or alcohol misuse
- 80% supported with a safeguarding issue or protected from abuse

Financial Summary

There are over 100 support staff working across the city. Engage Leeds is funded by Leeds City Council Adults and Health Commissioning on a long term contract for up to 8 years.

A formal return on investment has not been calculated but there is significant anecdotal evidence of positive reduction in costs avoided as well as better outcomes.

Approach / Methodology

The Engage Leeds consortium is based on shared values, a restorative and strengths-based approach, single service identity, city wide consistency of access, delivery and quality, and one case management system.

Support is available to anyone over the age of 18 and across all needs groups and so a Single Point of Contact and multi disciplinary set up is vital.

800 referrals are received per quarter and length of support is based on need. The biggest client cohort receives support for between 1 - 6 months so that demand / capacity can be managed without waiting lists and that people with higher levels of need can have their support sustained.

Supporting all adult needs groups necessitates a huge range of referral pathways: there are approximately 30 currently in place to and from key agencies, meaning that information sharing and appropriate risk management are essential.

Engage supports its partners both operationally and strategically.

Key learning

Critical factors in the success of Engage include:

- Single identity and a shared case management system
- Clear performance framework that was reflected through referral, assessment, support planning and outcomes documentation / service tools
- Single point of access and a smooth client journey
- Genuine restorative practice, backed up by tools and training for workers
- Housing support is complemented by specialisms that focus on maximizing income, access to employment, training or education and opportunities for peer support / volunteering, all of which contribute to people being able to sustain their accommodation and improve their wellbeing.

18. Sanctuary

Sanctuary provides vital practical and emotional support for people in Kirklees experiencing domestic abuse to remain safely in their home.

Summary

The Sanctuary scheme is available to anyone, male or female living in Kirklees who has suffered domestic abuse, whether they own or rent their home (providing landlord/ mortgagees give consent).

The scheme uses a multi-agency approach to help survivors of abuse to remain in their own homes, safe from their abusers, and offers free security protection (alarms, window and door locks and security lighting) as well as emotional and practical support.

The scheme is offered across genders, singles, households with children and across all housing tenure types.

It allows people to remain in the family home for stability, practical reasons such as children remaining in the same to school and to remain close to positive support networks. The service has been operational since 2006.

The partners in the Sanctuary scheme are Kirklees Council, Kirklees Neighbourhood Housing and Pennine Domestic Violence Group (PDVG).

Social Impact

Supporting individuals and households to remain securely in their home after abuse means children are not uprooted from their schools and adults can maintain their support networks which can help with their resilience.

This is coupled with emotional and practical support from a domestic abuse specialist support worker and enables the person to build up coping mechanisms so they are less likely to return to the abusive relationship.

Preventing homelessness has a positive impact on the household, they do not have to go into temporary accommodation, relieving pressure on the local authority and refuges.

Case Study Theme:
Domestic Violence

Location: **KIRKLEES**

Around 100 households a year are helped through this scheme. In a recent survey, of those service users who gave feedback when support ended, 80% reported feeling safe and 60% reported feeling more confident. When asked about what the impact of Sanctuary has been, 84% felt they are better equipped to recognise abusive behaviour in the future and more confident to ask for help if needed.

Sanctuary scheme outcomes show that 93% of people whose property was made secure remained in their homes for at least 3 months after installation of security measures.

Health Impact

Sanctuary ensures that a home is as physically secure as possible so that abusers cannot enter the home to cause physical or psychological harm to the people there.

Being able to remain in the home after an abusive person leaves means the household does not have to change GP practice and provides continuity of care, which can be particularly important if there are children in the family.

When families become homeless access to health services can be the last thing on their minds and therefore if a health problem occurs they are more likely to seek out more expensive urgent or emergency services. Remaining in the home and maintaining support networks has a positive effect on wellbeing both physical and mental.

Financial Summary

Costs vary depending on demand. Currently the cost of the target hardening property safety measures are around £20k per year and the cost of a support worker £30k. Floating Support costs provided by Pennine Domestic Violence Group (PDVG) are met via Housing Related Support and the safety measures are paid for by the Housing Solutions Service using homelessness prevention funding.

Approach / Methodology

The key driver was to support people to live without violence and to prevent homelessness. It was a housing initiative but built on partners' specialisms (e.g. PDVG) rather than start something new.

Challenges have included getting providers of the services to understand the cost of the service and we have worked hard to ensure all understand the remit of the scheme.

Key learning

The scheme saves money across the public purse and more importantly it keeps people free of violence, provides reassurance and prevents homelessness during a traumatic time.

The scheme has been reviewed as some costs were increasing and the scope of support workers to order works was updated, noting that some equipment could be sourced elsewhere.

The success of the scheme has been down to the partnership being willing to work together.

19. Activage

Activage in Leeds worked with Samsung to pilot using its smart technology to support better ageing, maintain independence and improve people's communication with their family, friends and carers.

Case Study Theme: Healthy Ageing

Location: **LEEDS**

Summary

Leeds City Council, in partnership with Samsung (technology provider) University of Surrey (evaluator) and CSEM (algorithm developer) is the only UK site in an EU-wide Horizon2020 funded (£25m) programme.

Participation is open to any Leeds resident aged 65+ who has home broadband and who scores between 2-6 on a self assessed frailty scale (i.e. people with mild or moderate frailty).

A Samsung smartphone, connected smart watch and home sensors are provided. Data is automatically shared according to the participant's wishes, most commonly with their family and carers. The smart watch can be used to monitor health markers such as heart rate, sleep pattern, medicine prompts or step count. The home sensors can, for example, monitor use of appliances such as kettle or TV, door opening/closing and movement around the home.

The pilot project phase is 2017-2020.

Social Impact

Quantitative data is being collected by evaluators but will not be analysed until the project ends. Qualitative feedback from participants suggests some benefits but also some negatives:

- "This has given me my independence back."
- "I have learnt the skills to use technology."
- "This is too complicated for me."
- "I don't think it's suitable for my age group!"

Health Impact

Participants gaining the most benefit appear to be those who use it to monitor their own health:

- Sleep monitoring has provided reassurance to those who previously believed themselves to be poor sleepers.
- The step counter function motivates participants to be more active.
- Family members and carers report decreased stress levels because of the peace of mind provided by the digital communication and updates.

Financial Summary

Funding was from the Horizon2020 programme and return on investment will be included in the evaluation in 2020. However, there have already been benefits from the relationship between Samsung and Leeds City Council for wider developments across the city.

Approach / Methodology

The initial contact for the project came via the Smart City Leeds team who had an existing working relationship with Samsung.

The project team consists of 3 part time posts: project lead, project support officer and admin support. The Project Board includes a project sponsor at senior level in the council and a local GP. There is also a User Group of project participants.

Key learning

Learning from the implementation to date includes:

- Participants need an existing level of digital literacy
- Home broadband as a pre-requisite has excluded many who would have benefited.
- Working with a private sector organisation can be challenging due to differing priorities
- Citizen engagement is best achieved face-to-face
- Technological support has had to be provided by the project team

Much of the associated learning from the practical aspects of this project have informed the City Digital Strategy and work on digital inclusion.

20. Extra Care Housing

Extra Care Housing is an integrated approach that allows the housing, health and social care needs of people to be met as they move through later life. Kirklees has an ambitious plan to increase the number of self-contained homes with design features and support services that enable older people to access self-care and independent living.

Summary

Kirklees Council is committed to delivering up to six new older people's Extra Care Housing schemes on its own land. The schemes will provide specialist housing with extra facilities, services and potential to increase care according to need. Initial plans include the development of a scheme at Kenmore Drive, Cleckheaton which is estimated to start in January 2021 and complete in November 2022 .

Unsuitable housing has a negative impact on quality of life in older age and can be a source of multiple problems and associated costs. There is a specific need now and in the future in Kirklees for more Extra Care for rent and sale. The net additional extra care provision needed by 2030 is estimated to be 1016 units (388 units of housing with care for rent and 628 additional units for sale or shared ownership).

This development will consist of appropriately designed housing that can adapt as people's needs change as they age, the benefits being reduced demand on care and enabling individuals to live independently and more flexibly in later life.

The scheme is expected to deliver 79, 1-bed and 2-bed apartments for affordable rent with integrated care support. The scheme will target people aged 55+ living in Cleckheaton, Batley and Spen Valley.

The development will also bring a range of socio-economic benefits to the area.

Case Study Theme:
Supporting Hospital Discharge (Including Aids and Adaptations)

Location: **KIRKLEES**

Planned Social and Health Benefits

The planned evaluation framework and KPIs include:

- Number of older people housed in appropriate homes
- Number of older people benefitting from improved warm homes
- Number of jobs and apprenticeships created and people achieving NVQ skills
- Health, wellbeing and independence – hours spent on activities to enable this
- Reduction in hospital admissions /council budgets
- Reduction in council costs of placing in inappropriate care home
- Reduction in carbon emissions
- Resident participation in activities

Financial Summary

The estimated project build cost is in the region of £13.5m. It is expected this will be funded via - Homes England Shared Ownership and Affordable Housing Programme Grant, registered provider's own funds and borrowing and land value.

Approach / Methodology

The Council is working in partnership with a specialist registered housing provider, Housing 21. The Council will dispose of the site to the provider with appropriate conditions. Housing 21 will then develop and manage the scheme.

A cross service Specialist Housing Board has been established to oversee all specialist accommodation projects (includes representatives from Strategic Housing, Adults Commissioning and Housing Growth). This ensures an integrated approach to housing delivery and care.

Key barriers / challenges

The scheme is currently at an early stage but the following challenges exist:

- The timeline to get to delivery has taken longer than anticipated due to partner processes and capacity and site issues
- Cost of Extra Care is high due to the presence of non-residential areas in the scheme (eg. restaurant) and abnormal site costs. This has impacted on viability and the ability to provide shared ownership options.
- High level of grant is required from Homes England to make the scheme work which presents a risk to delivery.
- Disposal of site will need to be approved by Cabinet

Key learning

Scheme is currently at an early stage and success is not yet measurable. Key learning to date includes:

- Need to define expectations that both parties sign up to at the start of the process to help keep things on track
- A visit arranged for Council Cabinet members to see a scheme in operation has helped them understand what the product offers and why costs are high. They are now acting as advocates for this type of scheme which will help ease the project through the democratic process.

21. Shared Lives

Shared Lives supports adults with learning disabilities in North Yorkshire to maximise their independence within the support of a family environment.

Summary

The essence of Shared Lives is that instead of staying in a residential facility, or being supported by a team of Support Workers, someone with a learning disability can choose to become part of a real family.

It is designed to work around someone with a care need: a learning disability, dementia, physical disability or mental health need, as an alternative to more traditional, less personal methods of care.

It aims to help tackle loneliness, reduce isolation, help people recover after hospital treatment or mental ill health. It is built on flexibility, family and what a person needs: that can be a day at a time, a few days or a full time living arrangement.

The aim is that for all members of a Shared Lives family everyone becomes more valued, more active members of the local community, with the opportunity to jointly pursue passions and interests, learning new skills and supporting each other as a family – not as a service.

Social Impact

A key element of the Shared Lives service is around people being supported to be part of their local community and access a range of services to help meet their outcomes. This can be accessing a wide range of health, social care, voluntary sector and other organisations.

Health Impact

People in Shared Lives are supported to access health services on a regular basis by their carers and benefit from being able to access community healthcare.

Case Study Theme:
Learning Disability

Location: **NORTH YORKSHIRE**

There is also an in built emphasis on happiness, wellbeing and being proactive in being healthy.

Financial Summary

North Yorkshire County Council commission Avalon through a block contract to manage the Shared Lives service, including recruitment and management of the carers who run the service. Avalon pay the carers on a tiered basis depending on levels of need.

Approach / Methodology

Once a person identifies that they may wish to become part of a Shared Lives family (part time or full time) Avalon Group works to match them to the right family.

The Matching Process is designed to make sure all members of the Shared Lives family are compatible, in terms of interests and hobbies and also in lifestyle and home environment.

This might include matching people based on practical considerations – such as homes suitable for wheelchairs. As well as matching people who have shared interests such as music or sports.

Before any arrangements are finalised, all parties are support to meet several times so that they can all get to know one another and all agree that it is a good match.

The Matching Process can take time to get right but is the most important feature in a successful ongoing Share Lives family relationship.

Key learning

Key challenges have been:

- the management of holidays for carers
- ensuring that the service builds people's independence skills
- and recruitment of carers within a limited budget.

Shared Lives has been proven to be a great option for some people and provides positive outcomes for people's care and support needs and general quality of life.

Further work will be needed in the future to promote this as an option and renew the model to ensure it maximises people's skill development and keeps them part of their local community.

22. Mental Health Navigators

Mental Health Navigators in Wakefield support people with mild and moderate mental health issues to stay living independently by providing practical and emotional support to maintain their tenancies and improve their mental wellbeing.

Summary

Wakefield has a clear vision to improve the mental health and psychological wellbeing of people across the district by supporting the prevention of mental health problems and investing in early intervention.

Wakefield District Housing (WDH) and Wakefield CCG jointly fund a team of three Mental Health Navigators. The team supports WDH tenants with low to moderate level mental health support issues. Through timely and appropriate treatment such as coping mechanisms and strategies to manage their own wellbeing, tenants are supported to maintain their tenancies and to prevent escalation into secondary mental health services.

The service is delivered in partnership with South West Yorkshire Partnership NHS Foundation Trust (SWYFT) who provide clinical supervision to the Mental Health Navigators. The service is for any WDH tenant presenting with low to moderate mental health issues and not in receipt of secondary mental health services.

Social Impact

WDH manages over 31,000 properties and estimates that 1 in 4 people experience some form of mental health problem. Investing to support the people living in these tenancies to improve their mental health and remain in their home is a priority.

Early intervention with the right level of mental health related support has proven to avoid failed tenancies, and resultant homelessness, also reducing the need for secondary or acute mental health care.

In the first year Mental Health Navigators were on staff, there was a 25% drop in tenancy failure rates.

Case Study Theme:
Mental Health

Location: **WAKEFIELD**

Health Impact

Without the Navigators, tenants may experience increasing anxiety or other mental health issues, resulting in more GP attendances and increased use of secondary or acute mental health services.

There is a proven link between failure of tenancies and homelessness, ill health, sectioning under the mental health act and crime. Supporting people to sustain their tenancy is a key component of people living independently and avoiding the harm and long term costs of negative outcomes.

To measure the impact, Navigators use the Modified Sainsbury Tool (an initial risk assessment tool for primary care mental health and learning disability services) and a 'DIALOG' assessment (where people rate their satisfaction with eight life domains and three treatment aspects on a 7-point scale.)

Financial Summary

The social return on investment in 2018/19 on 632 people was calculated to be a return of £16.29 for every £1 invested.

312 referrals in 2018/19 included an anti-social behaviour indicator (victim or perpetrator) which was successfully removed in 79 cases after intervention by the team.

The cost of turning round an empty property is in the region of £3,000, so the total return on investment to WDH was in the region of £237,000.

Approach / Methodology

Previous work on Health Inequalities in Wakefield had identified that a high number of WDH tenants were identifying with mild to moderate mental health issues but with little or no support available for this locally.

This gap in service provision was impacting on their ability to successfully maintain and manage their tenancy agreement such as meeting internal and external maintenance standards or financial obligations such as paying rent and acquiring associated benefits.

By working in partnership with the CCG and SWYFT, three Mental Health Navigators were employed in a pilot project, focusing on prevention and early intervention, to stop tenancy breakdown and more costly interventions. Ensuring tenants received early help to improve their mental health and quality of life.

Key Learning

An evaluation by York Consulting, showing that the "whole system" approach delivers both a cost benefit and a proven reduction in tenancy breakdowns.

Benefits also included WDH workers reporting a positive impact on tenants and improved professional relationships with them.

The early health provided by Navigators has become fundamental to WDH's tenancy management and referrals are increasing by 30% year on year.

Both qualitative and quantitative data supported the decision to make the Mental Health Navigators permanent posts within WDH with funding secured from health and care system partners in Wakefield.

Conclusion

Insights and Recommendations

A review of the literature tells us that housing is one of the significant determinants of health and wellbeing (PHE 2018). The impact on physical and mental wellbeing of living in an unhealthy home can be profound, particularly for children and their long term health, with a direct financial impact on local health and care systems. For older people, living in an appropriately adapted and accessible home with support has a positive impact on reducing the length of hospital stay and the incidence of falls and hip fractures. Tenancies that would otherwise breakdown (leading to deterioration in mental health and potential homelessness) can be sustained with proper support delivered early, especially where people have multiple complex needs. The impact of the Covid-19 pandemic has exacerbated health inequalities. Whilst the full extent of this impact is as yet unknown, what we do know, is that the partnerships between housing and health will be crucial to supporting future improvements.

Looking to the future, the West Yorkshire and Harrogate Health and Care Partnership continues to focus on improving population health. Through effective Population Health Management we can use data from multiple sources - local authorities, NHS, housing associations, voluntary sector - and gathering in- depth current and historic information to better understand what factors, such as housing, are affecting the health of different population groups in our area. By using such data, future housing initiatives could be precisely designed to target the specific health needs of a locality or population group.

Partners are committed to working together to increase the use and spread of population health management techniques to help better plan, commission and deliver health and care services. Based on the evidence collated through this review, there is a strong argument to increase the presence of colleagues from the housing sector within our population health management working groups.

Recommendation

Consider how the housing sector can increase contribution to the work being undertaken across the region to improve the impact of Population Health Management

In its response to the 2019 NHS Long Term Plan, West Yorkshire and Harrogate Health and Care Partnership has developed a Five Year Plan that recognises the role of housing for health and includes ambitions related to the importance of housing and the sharing of good practice. Specifically, it commits the Partnership to build on learning from housing initiatives across the region, improve the environment in which people live and consider the role housing services can play in supporting good health and wellbeing.

However, we know that there is work to be done in strengthening the way we transfer learning across our geography. This could be accelerated through the development of a dedicated, focussed, working group designed intentionally to transfer knowledge and understanding of outcomes across the partnership.

Recommendation

Establish a West Yorkshire and Harrogate 'Innovation in Housing' working group to facilitate the spread and adoption of innovative housing initiatives.

The case studies included here represent a quick insight into some regional activity, highlighting initiatives that improve health and wellbeing and reduce the financial impact on local health and care services.

Key benefits to people and to the health and social care system demonstrated in the case studies include improved health and wellbeing, individuals increasing their independence and retaining it for longer as well as decreased length of hospital stays and reduced need for urgent and emergency care. More efficient discharge with follow-up support means that people may be less likely to require residential care, less likely to be re-admitted to hospital and less likely to use GP or ambulance services. Being discharge at the right time, with the right planned support can also promote faster recovery and better outcomes.

Appropriate accommodation and, where required, adaptations mean that hazards are removed resulting in fewer falls and accidents, increased confidence and a feeling of safety, all of which build in physical and mental wellbeing.

Money-related stress can lead to the breakdown of tenancies and ultimately to homelessness. Expert money advice to maximise benefits and manage debt, along with interventions to make homes more energy efficient and therefore cheaper to run, can all have a positive impact on mental and physical wellbeing.

Housing initiatives that promote social activity such as group exercise sessions are reporting that the people involved are more connected, more active and experience less loneliness.

In summary, this collection of local case studies provides evidence of how well designed housing and person centre housing support initiatives have a direct positive impact on health and wellbeing. While some initiatives have been able to share quantitative data to demonstrate their impact, others are still in the early stages of collecting information on outcomes. Additionally, some of the case studies involve small numbers of people but have demonstrated a significant effect for those individuals. If these interventions were extrapolated across the wider population of West Yorkshire and Harrogate, there could be significant health benefits across the region.

Recommendation

Identify three specific case studies demonstrating positive impact across one place and potentially through a newly created 'Housing in Innovation Group', focus on the spread and adoption of the learning across the whole partnership.

The importance of our housing initiatives across West Yorkshire and Harrogate will be crucial in supporting our health economy. The Covid-19 pandemic has put the basic need for good quality housing and support to sustain a decent home, in the spotlight. The Partnership's report' Housing for Health' provides an opportunity to accelerate and develop our shared learning and adopt best practice across our geography. This in turn will help address inequalities and improve the standard of living for people living across West Yorkshire and Harrogate.

We will be using the learning from this report to develop our system-wide work plans and progress our ambitions.

Contact

For more information relating to housing for health gain projects or any of this work, please contact:

Sarah Roxby
Associate Director – Health, Housing and Transformation
Wakefield and District Housing Ltd

Rachael Loftus
Head of Regional Health Partnerships
WYandH Health and Care Partnership

Oliver Barnes
Programme Lead
Yorkshire and Humber AHSN

West Yorkshire and Harrogate Health and Care Partnership
www.wyhpartnership.co.uk
westyorkshire.stp@nhs.net
@WYHpartnership

Yorkshire and Humber AHSN
www.yhahsn.org.uk
info@yhahsn.com
@YHAHSN

References

References

Audit Commission (2009). Building Better Lives: Getting the best from strategic housing [online]. Report. Available at: https://www.bl.uk/collection-items/building-better-lives-getting-the-best-from-strategic-housing-local-government (Accessed on 17 July 2019).

BMA (2016). Older people and the social determinants of health. Briefing paper. Available at: https://www.bma.org.uk/collective-voice/policy-and-research/public-and-population-health/healthy-ageing (Accessed on 7 August 2019)

BRE (2015). The cost of poor housing to the NHS [online]. Briefing paper. BRE website. Available at: www.bre.co.uk/healthbriefings (Accessed on 17 July 2019).

Centre for ageing better. (2019). Home truths Housing options and advice for people in later life: Learning from communities in Leeds (Accessed 12 Sept 2019) Available at: https://www.ageing-better.org.uk/sites/default/files/2019-07/Home-truths-report.pdf

Chartered Institute of Housing. (2014). How to create Sustainable Tenancies (Accessed 10 September 2019) Available at: http://www.cih.org/resources/PDF/Policy%20free%20download%20pdfs/How%20to%20create%20sustainable%20tenancies.pdf

DEMOS (2017). The Social Value of Sheltered Housing. Briefing paper https://demosuk.wpengine.com/wp-content/uploads/2017/06/Sheltered-Housing-paper-June-2017.pdf (Accessed on 12 September 2019)

Department for Communities and Local Government (2006). A Decent Home: Definition for guidance and implementation [online]. Available at: https://www.gov.uk/government/publications/a-decent-home-definition-and-guidance (Accessed on 21 July 2019).

Garnham, L. and Rolfe, S. (2019) Housing as a social determinant of health [Online]. Available at https://www.gcph.co.uk/assets/0000/7295/Housing_through_social_enterprise_WEB.pdf (Accessed 20 July 2019).

Gentoo Group (2016). Boiler on prescription trial: Closing Report [online]. Available at: https://www.gentoogroup.com/for-customers/news/2016/march/boilers-on-prescription-scheme-reduces-gp-appointments-by-60/ (Accessed on 23 July 2019).

Ministry of Housing, Communities and Local Government (2019b). English Housing Survey: 2017-8 [online]. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/774820/2017-18_EHS_Headline_Report.pdf (Accessed on 18 July 2019).

National Audit Office (2017). Housing in England: Overview [online]. Available at: https://www.nao.org.uk/report/housing-in-england-overview/ (Accessed 20 July 2019)

National Institute for Healthcare and Excellence (2017). 'Liverpool Healthy Homes: Delivering Sustainable health and housing improvements' [Online]. Case Study. Available at: arms.evidence.nhs.uk/resources/qipp/1059400/attachment (accessed 17 July 2019).

NHS (2019). Long Term Plan [online]. Available at: https://www.longtermplan.nhs.uk/ (Accessed 17 July 2019).

Public Health England (2017). Health Profile for England 2017 [online]. Available at: https://www.gov.uk/government/publications/health-profile-for-england/chapter-5-inequality-in-health (Accessed on 19 July 2019).

Public Health England (2018). 'Prevention and the NHS Long-Term Plan: 3 ways we can save more time' [online]. Blog. Available at: https://publichealthmatters.blog.gov.uk/2018/09/06/prevention-and-the-nhs-long-term-plan-3-ways-we-can-save-more-lives/ (Accessed 26 July 2019).

Public Health England (2018). Health Matters: Reducing health inequalities in mental illness [online].Blog. Available at: https://publichealthmatters.blog.gov.uk/2018/12/18/health-matters-reducing-health-inequalities-in-mental-illness/ (Accessed on 7 August 2019)

Public Health England (2019). Inequality Tools [online]. Tool. Available at: https://fingertips.phe.org.uk/profile/inequality-tools (Accessed 25 July 2019).

Shelter (2006). The Chance of a Lifetime: The impact of bad housing on children's lives. [online] Available at: https://england.shelter.org.uk/__data/assets/pdf_file/0016/39202/Chance_of_a_Lifetime.pdf (Accessed 17 July 2019).

Shelter and Comres (2017). The Impact of Housing Problems on Mental Health [Online]. Research project. Available at: http://england.shelter.org.uk/__data/assets/pdf_file/0006/1362885/Findings-The-Impact-of-Housing-Problems-on-Mental-Health.pdf (Accessed 19 July 2019).

World Health Organisation (2018). WHO Housing and Health Guidelines. [Online] Available at: https://www.who.int/hia/housing/en/. (Accessed 17 July 2019).
Housing Act (2004). Housing Health and Safety Rating System: Operating Guidance. [online] Available at: https://www.gov.uk/government/publications/hhsrs-operating-guidance-housing-act-2004-guidance-about-inspections-and-assessment-of-hazards-given-under-section-9 (Accessed on 21 July 2019).

Housing LIN (2017). The Lightbulb Project: Switched on to integration in Leicestershire [online]. Case Study 135. Available at: https://www.housinglin.org.uk/Topics/type/The-Lightbulb-Project-Switched-on-to-integration-in-Leicestershire/ (Accessed on 17 July 2019).
Joseph Rowntree Foundation (2017). UK Poverty 2017. Available at: https://www.jrf.org.uk/report/uk-poverty-2017 (Accessed on 7 August 2019)

King's Fund: Housing and Health Report; Opportunities for sustainability and transformation partnerships (2018). Available at: https://www.kingsfund.org.uk/sites/default/files/2018-03/Housing_and_health_final.pdf (Accessed on 7 August 2019)

Local Government Association (2019). The Cost of Unhealthy Housing to the NHS [online]. Briefing paper. Available at: https://www.local.gov.uk/parliament/briefings-and-responses/cost-unhealthy-housing-nhs-house-commons-26-february-2019 (Accessed 19 July 2019).

Marmot Review: Fair Society, Healthy Lives (2010). Available at: http://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review/fair-society-healthy-lives-full-report-pdf.pdf (Accessed on 7 August 2019)

Mental Health Foundation: Housing and mental health [webpage]. Available at: https://www.mentalhealth.org.uk/a-to-z/h/housing-and-mental-health (Accessed on 7 August 2019)

Ministry of Housing, Communities and Local Government (2019a). Statutory Homelessness, October to December (Q4) 2018: England [online]. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/804329/Statutory_Homelessness_Statistical_Release_October_to_December__2018.pdf (Accessed on 18 July 2019).

UK Green Building Council (2018): Healthy housebuilding: making 300,000 home better places to live. Available at: https://www.housinglin.org.uk/_assets/Resources/Housing/OtherOrganisation/Healthy-Housebuilding.pdf

Scottish Government (2018). Tackling social isolation and loneliness: consultation analysis. Available at: https://www.gov.scot/publications/analysing-responses-connected-scotland-scottish-governments-draft-strategy-tackle-social-isolation-loneliness/pages/5/

Homeless Link (2019). Homelessness and health campaign (webpage). Available at: https://www.homeless.org.uk/our-work/campaigns/policy-and-lobbying-priorities/homelessness-and-health-campaign

University of Sheffield et al. (2017). Going Further Back to Prevent Homelessness. Available at https://wy-fi.org.uk/homelessness/ (Accessed on 12 Sept 2019)

Health Foundation (2020) Emerging evidence on COVID-19's impact on health and health inequalities linked to housing [online] Available at (https://www.health.org.uk/news-and-comment/blogs/emerging-evidence-on-covid-19s-impact-on-health-and-health-inequalities) Accessed 05 October 2020

Centre for Ageing Better and King's Fund (2020), Homes Health and COVID-19 [online] Available at (https://www.ageing-better.org.uk/publications/homes-health-and-covid-19) Accessed 05 October 2020

YORKSHIRE & HUMBER
ACADEMIC HEALTH SCIENCE NETWORK

West Yorkshire and Harrogate
Health and Care Partnership

October 2020